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ABSTRACT

The VIISA (Vision Impaired In-Service in America) training model provided early intervention/childhood professionals with training that would help them better serve preschoolers, ages birth to five, with blindness and visual impairment. Materials and procedures for two courses were developed and taught to 344 participants in 9 states over a 3-year period. The first course focused on working with infants and toddlers in home-based programs and the second course focused on working with children ages 3 to 5 and their families in center-based preschool settings. Each course was taught over an 11 to 13 week period and consisted of: (1) an initial onsite classroom teaching at a central location; (2) homestudy units, with readings and written assignments to be mailed to the instructor, some involving observations and hands-on minipracticum experiences; (3) a 3-hour class involving videotaped material and a conference call between instructor and students located at regional sites; and (4) a final onsite class. Through the courses, participants became acquainted with specialized learning needs, curricula, teaching strategies, assessment tools, and learning materials. Near the end of the project, staff trained local instructors and assisted seven states in setting up the inservice training model using their own state instructors. This final report describes objectives, conceptual framework, activities, evaluation findings, and future activities. Appendices contain materials from the courses' training guides and program evaluation questionnaires. (JDD)

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ED 380 933

FINAL REPORT

to

U.S. Department of Education
Office of Special Education Programs
Early Education Program for Children with Disabilities--Model Inservice Training Projects

CFDA 84.024P

by Project VIISA

A National Inservice Training Model for Training Early Interventionists in A Low Incidence Disabling Condition: Visual Impairment

Award #H024P10007-92

SKI-HI Institute
Department of Communicative Disorders
Utah State University
Logan, Utah 84322-1900

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II. Abstract or Executive Summary

A National Inservice Training Model for Early Interventionists in a Low Incidence Disabling Condition: Visual Impairment

Project VIISA

Elizabeth C. Morgan, M.A., Director

The VIISA Inservice Training Model was designed to provide early intervention/childhood professionals serving preschoolers, ages birth to five, with blindness and visual impairment with training that would help then better serve these young children and their families. All of the project's efforts were coordinated through a contact who was part of a VIISA task force in the state that had representatives from early intervention (Part H), early childhood (Part B), CSPD, and state vision services.

Through this project, materials and procedures for two courses on working with young children with blindness and visual impairments were developed. The courses were taught to 344 participants in 9 states over the three-year period with 200 of these completing both courses. The courses, materials, and project staff were evaluated quite highly by these participants. The first VIISA course focused on working with infants and toddlers with blindness and visual impairments in home-based programs and the second course focused on working with this population of children, ages 3 to 5, and their families in center-based preschool settings.

Each course was taught over an 11-13 week period and consisted of : (1) An initial nine hours of onsite classroom teaching at a central location over a Friday evening and Saturday; (2) 7 to 8 homestudy units with readings and written assignments to be mailed to the instructor. Some of these assignments involved observations and hands-on minipracticum experiences with infants, toddlers, and preschoolers who are blind and visually impaired; (3) A three-hour class involving material on video tape and conference call between the instructor and students located at regional sites throughout the state. This session took place midway through the quarter; (4) A final nine hour onsite class with the instructor at a central location over a Friday evening and Saturday. Because VIISA participants expressed a

preference for having more onsite time with each other and the instructor, the distance education session was eventually eliminated and onsite class times increased to two days.

Student grading was based on portfolio assessment and attendance/participation at the two onsite and one distance education classes.

Through the courses, participants become acquainted with the specialized learning needs of young children with visual impairments as well as the concerns of their families. They are familiarized with a variety of teaching strategies, curricula, assessment tools, and learning materials appropriate for use with this population. Participants also learn about the vision agencies and professionals they should be working with in providing services to these children as well as how to access these special services.

The primary text that has been used with both courses is a two-volume 1,200 page resource manual for early intervention and early childhood personnel working with children who are blind and visually impaired. It was developed by the SKI-HI Institute at Utah State University from 1990-1992 with the help of a variety of professionals who have worked with this age and disability group from across the nation. This manual underwent some revision and update in the Fall of 1994.

VIISA is a cost effective model. Participants take a minimal amount of time from their jobs to receive the training. Assignments and readings are completed at home and many of the practicum assignments can be done with children with visual impairments in their local programs.

Near the end of this grant, project staff went back into 7 of the states to train local instructors and to assist each state in setting up the inservice training model through the use of their own state instructors who work in teams. In this way, each of these states will be able to continue to offer the needed inservice training to professionals in their state on an ongoing basis. The project also provided these states with instructor manuals for the courses and other training package material. The project continues to keep in touch with these demonstration sites to provide technical assistance as needed.

In the Winter and Spring of 1995, five of these states will be offering the VIISA course on infants and toddlers under the instruction of their state training teams. They will then follow up with the preschool course in the summer and fall. Some of them are having a national VIISA instructor co-teach with their local training team. Others have just requested some consultation from a national VIISA instructor through their first course. In addition to the full courses, two of the states are using their state instructors to provide one day regional mini inservice workshops for a wide variety of people working with this population of children.

In December of 1993, VIISA project staff wrote and submitted a federal grant, applying for funding to move the project into Outreach status. This new outreach grant has been funded, starting October 1994. This new grant will enable the project to work with new states as well as provide technical assistance to the demonstration sites.

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IV. Final Report on Objectives and Activities of the Project Over the Three Year Grant Period

Objective #1

> To develop two courses based on a comprehensive curriculum for serving children who are visually impaired in a non-categorical, least restrictive environment.

The project director together with the six national VIISA instructors spent the first six months of the project developing the content, materials, and procedures for the two VIISA courses. Both courses were piloted in Ohio and changes were made as needed before teaching both courses in the remaining states. Then, during the last six months of the grant, these same project staff members made final revisions to the content and materials for both VIISA courses. In addition, the two-volume text for the VIISA courses went through some revision and update. All of this final work was based on feedback obtained from the participants in the courses over the three year grant. Below is a descriptive timeline on how this first objective was accomplished.

1. In November 1991, copies of the 1200 page course text were mailed to instructors to look over (See Appendix B). Then a detailed proposal for content of the first course was mailed to instructors for their feedback. Based on that feedback, they were given assignments of specific home study units and onsite topics to develop.
2. In January 1992, the six instructors came to the project headquarters in Logan to spend 2 1/2 days to finish putting the first course together and help develop project plans. The first course was on Working with Infants and Toddlers Who are Blind and Visually Impaired and Their Families. Work was also begun on the second course, Working with Preschoolers with Blindness and Vision Impairment in a Variety of Center-Based Settings.
3. By March 1, 1992, the home study and instructor manuals for the first course were in place and ready for the pilot site (Ohio) in April, 1992.

4. During the next four months, instructors worked on developing specific assignments for the second course. Phone conferencing and mailings were used to refine the materials and give each other feedback on those.

5. By July 30, the home study and instructors' manuals for Course #2 were in place and ready for the pilot site to be taught in the Fall of 1992.

6. Instructors now had copies of all course materials to teach from. See Appendixes C, D, and E for sample material and the content of the two home study and two course manuals. The VIISA instructors used these course materials from Fall 1992-Spring 1994 to teach both of the courses in the following states: Colorado, Wyoming, Louisiana, Missouri, South Carolina, Florida, Georgia, Iowa, and Massachusetts.

7. Minor adjustments were made along the way to materials as needed.

8. In April 1994, the VIISA instructors returned to the project office in Logan, Utah for 2 1/2 days to begin work on final revisions to all course materials. Each returned home with sections to work on. The rest of the work was completed by mail and phone contact. By August, 1994, the revised course and home study manuals were ready for packaging, dissemination, and use in the local state instructor training sessions scheduled in the following sites that September-October: Colorado/Wyoming, Ohio, Missouri, South Carolina, Florida, Iowa, and Louisiana.

9. The following manuals and materials for use in teaching the VIISA courses were fully developed by the end of this project:
   - Introduction to Instructors' Manuals
   - Instructor Manual for Infant/Toddler Course and accompanying Home Study Manual
   - Instructor Manual for Preschool Course and accompanying Home Study Manual
   - Transparencies and handouts for both courses
   - 5 video tapes for use in training
   - Binder of research articles for each course

Objective #2

> To organize and put in place an innovative instructional delivery system for each course using the following format: an initial 9 hour onsite session, home study assignments, a three hour distance education session midterm, and a final nine hour onsite session at the end of the course.

The project director together with the six national VIISA instructors spent the first six months of the project developing the instructional delivery system or format for each course at the same time as they were working on the content and materials for each course. This format was piloted in Ohio. One immediate change was to reduce the number of home study assignments in the first course from ten to seven. Feedback from both the participants and instructor indicated that ten assignments were way too much. Other minor changes in the portfolio grading system were also made.

One major change made to the format was to pull out the three hour midterm distance education session in each course and put that time plus a little more into the two onsites for each course. This midterm session involved having participants meet in smaller regional groups; view material on video tape for two hours; and then speak with their VIISA instructor for the final hour by group conference call about the content of the video and other issues of concern as they related to the course. This was the only distance education option that could fit into the project's budget. Live video teleconferencing was financially prohibitive. The overwhelming feedback from participants during the first course in each state was that they would prefer to be onsite longer with the instructor and do away with the midterm distance education session. So, it was eliminated for course #2 in each of the states and onsite time increased to two days each.

Project staff also put together a VIISA Management Manual by Spring of 1994 (See Appendix G). This manual provides procedural guidelines, sample letters, flyers, and forms that the VIISA task force and contact person in each state could use in setting up and implementing the VIISA Inservice Training Model in their state. This was a part of the process in getting these states to a point where they could continue with the course delivery once the federal project was completed. Each state was provided with two copies of this manual.

The timeline in which this objective was accomplished parallel that of Objective #1.

Objective #3

To determine and prepare states to receive the inservice training.

A letter with a brochure (See Appendix A) and information about the project along with an application form were mailed to each of the Part H, 619, and Vision Coordinators in all of the 50 states in December 1991. Responses by mail and phone were received from 15 states during the next couple of months. A strong level of commitment was required for a state to be chosen.

Three project staff members reviewed and scored those applications. By January 30, the pilot site, Ohio, was chosen. By April 1, six more sites (Wyoming, Colorado, Florida, Iowa, South Carolina, and Missouri) were chosen and indicated they would be ready by Fall 1992 and Winter/Spring 1993 to get going. By September 1992, the final two states were chosen (Louisiana and Georgia).

Local coordinators, dates, instructors, and locations were selected for these sites. cost sharing was decided with each state taking on a good share of the expenses (i.e., covering cost of text, travel, lodging for participants, and helping with travel of VIISA instructor). Some of the states ended up needing more time to get organized.

Objective #4

To select and prepare personnel to participate in the inservice training program.

The site preparation specialist worked closely with the contact person(s) in each state in giving them guidelines for selection. Each state then sent out large mailings to early intervention and preschool programs across their state with information about the courses, asking for interested professionals to apply. Some states had up to 75 applicants for the 25 participants slots.

Either the coordinator, or a small team of people involved with Part H, 619, and vision then made the final selection of participants. The final list of participants was then mailed to the project office in Utah which then mailed out registration packets.

Upon receipt of each registration, the project mailed their course materials (the two-volume text and Home Study Manual which contained detailed information about the course.) After seeing the amount of work involved, some registrants decided not to participate. So, the next person on the waiting list was given their slot. Participants were required to complete one home study assignment (readings and reaction paper) prior to the first onsite class. This assignment, along with a participant profile and pre-self evaluation was mailed to the VIISA instructor. The instructor would use this information in helping her with planning for the first onsite class.

Time was spent during the first hour of the onsite class to clarify any other questions and concerns participants had about the course, home study, and grading.

In Objective #7 the total number of participants who completed each course in each state has been listed.

Objective #5

To pilot teach each course in three locations.

Only one state, Ohio, was able to be ready to be a pilot site for the first course in Spring of 1992. Colorado and Wyoming were ready to start in Fall 1992. Ohio was then the pilot site for the second course in Fall 1992. Revisions were made to both courses after teaching them in Ohio. Students evaluated the course content, delivery system, instructor, and materials. Overall, the course materials, instructor and format were evaluated quite highly (see evaluation section starting on page 17). But as noted in Objective #2, the Ohio group recommended a reduction in the number of home study units which proved to be a good move. As also noted in Objective #2, the distance education sessions was eventually eliminated. Other minor revisions were made all along the way. Also, as listed in Objective #7, course #1 was taught in 9 states and course #2 in 10 states over the 3 year grant.

Objective #6

To evaluate and revise course curriculum and delivery systems as indicated by pilot (field test) information.

Participants were asked to fill out a pre and post self evaluation for the set of objectives for each course. They were also asked to fill out a final course evaluation for each course. State contacts also completed an evaluation of the project. This information was used all along the way to guide the project in making changes to the course materials and delivery system. All of this information is summarized in the evaluation section of this report. Overall the results were very positive. A majority of participants earned A's and B's in both courses. They were motivated folks who worked hard and gained a great deal from the VIISA course work.

One minute papers were used by the instructors at the end of every day of onsite training to give them feedback on what participants felt still needed to be addressed in the next day or next onsite class. This enabled VIISA instructors to make last minute adjustments to content and agenda in order to best meet the participants' needs.

Based on the evaluation data from the pilot site, Ohio, specific revisions were made to the home study manual to clarify instructions as well as to reduce the number of assignments to seven for course #1 and eight for course #2. Some changes were also made to the topics covered in the onsite sessions. Minor revisions were also made to the portfolio assessment procedures. These have been discussed in objectives #1 and 2 earlier. Final changes were made to the VIISA course formats and materials in Spring and Summer of 1994. These changes were in place for the next two sites receiving course #1 in Colorado and Wyoming by Fall 1993.

Objective #7

To teach the inservice course throughout the country.

Following is a listing of each of the nine states and when/where each course was taught, by whom, and the number of participants who completed each course. Notice that there were slightly fewer enrolled in the second course. This was often due to the realization of the work involved in doing home study assignments after the first course. A few participants from course #1 decided not to take course #2. Around 200 completed both courses in 9 of the states.

1)Ohio: Taught by Dr. Sheri Moore in Columbus. Course #1 in Spring 1992 with 18 completing. Course #2 in Fall of 1992 with 25 completing.

2)Colorado: Taught by Tanni Anthony in Denver. Course #1 in Fall 1992 with 23 completing. Course #2 in Spring 1993 with 18 completing.

3)Wyoming: Taught by Dr. Irene Toper in Casper. Course #1 in Fall 1992 with 17 completing. Course #2 in Spring 1993 with 14 completing.

4)South Carolina: Taught by Lois Hammett in Columbia. Course #1 in Spring 1993 with 21 completing. Course #2 in Fall of 1993 with 16 completing.

5)Missouri: Taught by Dr. Deborah Chen in St. Louis. Course #1 in Spring of 1993 with 17 completing. Course #2 in Fall of 1993 with 14 completing.

6)Iowa: Course #1 taught by Elizabeth Morgan in Spring of 1993 with 24 completing. Course #2 taught by Tanni Anthony in Fall 1993 with 22 completing.

7)Florida: Taught by Deborah Gleason. Course #1 in Fall of 1993 with 22 completing. Course #2 in Spring 1994 with 19 completing.

8)Louisiana: Taught by Dr. Irene Topor. Course #1 in Fall of 1993 with 23 completing. Course #2 in Spring of 1994 with 19 completing.

9)Georgia: Course #2 taught by Dr. Sheri Moore in Fall of 1993 with 23 completing. Part B-619 office sponsored the first course. Part H office fell through with plans on helping course #1 get off the ground.

10)Massachusetts: This was an extra small site taken on at no cost to the project. Courses were taught by Deborah Gleason as this was her home state and program. Course #1 in Fall 1993 with 5 completing. Course #2 in Spring of 1994 with 4 completing.

Objective #8

To package all the curriculum materials.

As noted earlier in Objective #1, VIISA project staff came back together in April 1994 to the project office in Logan, Utah. The purpose of this meeting was to begin the final revisions to the VIISA course material so that it could all be prepared for packaging and use in the state instructor training session in the Fall of 1994. By September, the following materials were completed:

1) Introduction to Instructors Manuals for both courses containing course descriptions, grading procedures, information, adult training strategies and activities, course evaluation procedures and forms, and information on preparing for and obtaining materials needed for VIISA courses.
2) Instructor Manual for Course #1 containing all the training guidesheets and white copies of handouts/transparencies for the onsite class topics. This manual also contains the home study manual for course #1 which contains all course information for participants along with the reading and assignment choices for each of the 7 home study units to complete for the course.
3) The Instructor and Home Study Manual for Course #2.
4) Five videotapes for use in the courses developed by the project. These include:
    a) Functional Vision Assessment for Infants and Toddlers
    b) Functional Vision Assessment for Preschoolers
    c) Infant/Toddler Case Study Video: Isaac and TJ
    d) Preschool Case Study on a Totally Blind Child in an Integrated Setting: Quinn
    e) Preschool Case Study on a Low Vision Child in an Integrated Setting: Morgan
    f) Teaching Self-Care Skills in the Context of the Daily Preschool Routine

*Note: Various videos from other sources were also purchased and used by the project. Ordering information on these has been provided to each state to add to their overall VIISA training package.

5) Binder of Research Articles for both course #1 and #2.
6) Project VIISA Management Manual.
7) A set of slides of adapted materials for use with this preschool population.

Each state was provided with a complimentary set of all the above materials. Each state also purchased extra copies of the instructor manuals since most were wanting to train teams of 6 and up to 12 people in their state. The project also provided each state with a disc of the home study management manuals so that they could make minor changes as needed to items such as the forms, as they work to individualize VIISA to their state.

All of the above materials were used in the state instructor training sessions in Sept. - Nov. of 1994. These individuals were quite impressed with the resources and useful material in these manuals. These manuals will be used by the state instructors in their first training sessions in winter, Spring and Fall of 1995.

These materials will undergo further revisions in preparation for use by the new VIISA Outreach Project in Spring of 1995. They are available for purchase by replicating sites through the VIISA project at the SKI-HI Institute.

Objective #9

To provide a means for continuation of inservice after completion of the project.

Following the offering of the courses in each of the original states, the VIISA project began to work with the main contact people and task forces in these states to help them put together a plan for continuing with the VIISA inservice training model. By the fall of 1994, seven of the states were ready to have VIISA instructors return to train local instructors. The project helped to provide training packages for each of these states. During this 3-day final onsite visit, the national VIISA instructor spent 1/2 day working out final details for training with the state's task force for VIISA as needed. The following 2 1/2 days were then spent training the local instructors and others as appropriate in the implementation of the VIISA training package. In the spring of 1994, four of these states will be offering the VIISA course on infants and toddlers under the instruction of the best instructors on their training team. All of the states are having two people team teach each course. They will then follow up with the preschool course in the summer and fall. Some of them are having a national VIISA instructor co-teach with their local training team. Others have just requested some consultation from a national VIISA instructor through their first course. In addition to the full courses, two of the states are using their state instructors to provide one day regional mini inservice workshops for a wide variety of people working with this population of children with blindness and visual impairment in Spring 1995. Other states are still working on their implementation plans.

In December of 1993, VIISA project staff wrote and submitted a federal grant, applying for funding to move the project into Outreach status. This new outreach grant has been funded, starting October 1994.

The VIISA Outreach Project proposes to work with three new states each year for a total of nine over the three years of outreach funding to develop and implement the VIISA Inservice Training Model for early intervention/early childhood personnel in their states who work with children birth through five who are blind and visually impaired and their families. The outreach project will also provide technical assistance to the states already implementing the model or adaptations of the model.

V., VI., & VII. Conceptual Framework and Description of the Model and Participants
Logistical Problems and How They Were Solved

Rationale

With the passage of Public Law 99-457, an increasing number of preschoolers who are blind and visually impaired are being served by a variety of noncategorical early intervention and early childhood programs across the country. Many of the professionals working for these programs lack the experience or training needed to adequately meet the specialized needs of these children and their families. Due to the shortage of teachers trained in the field of vision, many of the programs serving these children do not have access to adequate services from a teacher of children with visual impairments. In addition, not enough teachers certified in vision are prepared in early childhood education. Many states have not been able to develop and implement a comprehensive training program for the few professionals who will serve only a few special children. Herein lies the rationale for the VIISA inservice training model.

Purpose

Project VIISA is an innovative inservice training model funded by the U.S. Department of Education for a three-year period (October 1991-October 1994). It is housed at the SKI-HI Institute at Utah State University in Logan, Utah. Elizabeth Morgan has been directing the grant. The purpose of the project was to develop and then teach two courses which would provide inservice training to early intervention and early childhood professionals working with children ages birth to five who are blind and visually impaired in a variety of early education settings. The VIISA Project was to teach these two courses in nine states, then assist those states in setting up a system whereby they could continue with offering the courses on an ongoing basis through the use of their own state instructors by the end of the project. The VIISA Project has accomplished these goals.

Working With States

During the initial months of the inservice training project, awareness materials about the project along with a detailed application form requesting services were mailed to every part H, and part B coordinator in every state across the nation. The same materials were mailed to state vision consultants as appropriate. Responses and inquiries for more information both written and via telephone began to come into the project. During the next two months, project staff put a great deal of time and energy into correspondence both by mail and phone with the interested states. Project staff then completed a very careful selection process to narrow the choices down to the nine states that the project had funding to work with over the three-year period of the grant. Selection was based on statements of need, offers of coordinated state support, as well as commitment of financial assistance.

The nine states selected to receive Project VIISA services were: Wyoming, Ohio, Missouri, Colorado, Iowa, Louisiana, Georgia, South Carolina, and Florida.

The VIISA Project inservice training sessions were coordinated through the early intervention (part H), early childhood (part B), and state vision consultants in each of these nine states. They assisted project VIISA in contacting staff of early intervention and early childhood programs in order to identify interested and qualified people to take the course series. The state offices also assisted the project in identifying those programs willing to be practicum sites for VIISA students.

A state contact person was assigned to help the project with arrangements for local facilities to be used for the onsite and distance education classes along with mailing information to participants.

Approximately 20-25 persons in each state were chosen to take the course series. Priority was given to early intervention (EI)/early childhood (EC) personnel and vision consultants without EI/EC backgrounds presently working with an infant, toddler, or preschooler who is visually impaired in an early intervention or preschool program. These individuals had to have need for training to work with these preschool-age (birth through five) children. As of June 1994, a total of 344 professionals have taken the VIISA courses and 200 of these have completed both of the courses.

A national VIISA instructor was assigned to work with each state. These instructors are educators experienced and certified in working with young children with visual impairments. They included:

*Deborah Chen, Ph.D., California State University, Northridge
*Irene Topor, Ph.D., University of Arizona, Tucson
*Deborah Gleason, M.Ed., Perkins School for the Blind
*Lois Hammett, M.Ed., Tennessee Parent Infant Services
*Tanni Anthony, Ed.S., Colorado State Dept of Education
*Elizabeth Morgan, M.Ed., SKI-HI Institute
*Sheri Moore, Ph.D., University of Louisville, KY

Project VIISA covered the cost of the instructors' time and shared their travel expenses with each state. Students purchased the text and paid a $40 tuition fee for each course. They received 4 hours of credit for each course from Utah State University. VIISA explored with the state office and/or the LEA the availability of funds to help students with the cost of the text, travel, and lodging for the onsite classes. Most of the states were able to do this.

Course Overviews and Materials

The first VIISA course focused on working with infants and toddlers with blindness and visual impairments in home-based programs and the second focused on working with this population of children, ages 3 to 5, and their families in center-based preschool settings.

Each course was taught over an 11-13 week period and consisted of: (1) An initial nine hours of onsite classroom teaching at a central location over a Friday evening and Saturday; (2) 7 to 8 homestudy units with readings and written assignments to be mailed to the instructor. Some of these assignments involved observations and hands-on minipracticum experiences with infants, toddlers, and preschoolers who are blind and visually impaired; (3) A three-hour class involving material on videotape and conference call between the instructor and students located at regional sites throughout the state. This session took place midway through the quarter; (4) A final nine hour onsite class with the instructor at a central location over a Friday evening and Saturday. Because VIISA participants expressed a preference for having more onsite time with each other and the instructor, the distance education session was eventually eliminated and onsite class times increased to two days.

Student grading was based on portfolio assessment and attendance/participation at the two onsite and one distance education classes. There was no final exam.

A variety of teaching methods and materials were used in the onsite classes. These include lecture, video tapes, handouts, demonstrations, discussions, small group application sessions, practical experiences, and times to share ideas about specific types of children and to share resource materials.

The homestudy assignments involved reading of materials, reacting to them, applying what the participant had learned to real life situations with children and families in their local programs and then evaluating how they worked out. (See Appendix E, Home Study Manuals.) Some assignments required participants to make observations of children with visual impairment in a variety of settings. Participants had a variety of assignments in each topic area to choose from so as to better fit their individual needs and situations. These assignments were written and in some cases put on video tape or audiotape. They were then mailed to the instructor for grading and feedback.

Through the portfolio grading system, participants had an opportunity to redo assignments if they wished to take the time to do so to improve upon their work and gain more points for it. The instructor provided feedback on what needed to be improved upon in the assignment. In the end, the participant had a portfolio which could be used to show their best work to prospective employers or university programs.

Through the courses, participants became acquainted with the specialized learning needs of young children with visual impairments as well as the concerns of the families of these children. They were familiarized with a variety of teaching strategies, curricula, assessment tools, and learning materials appropriate for use with this population. Participants also learned about the vision agencies and professionals they should be working with in providing services to these children as well as how to access special services.

In particular, the infant/toddler course covers the following topics:

Unique needs of infants and toddlers who are visually impaired and their families; working with families; observation, assessment and developing the IFSP; service delivery options; support services needed; intervention techniques, resource materials to use in all developmental domains; developing the use of the senses, vision, touch and hearing; special needs of infants and toddlers with vision loss and additional disabilities/medical problems; transitioning issues.

The preschool course covers the following topics:

Unique needs of preschoolers who are visually impaired; observation, assessment and developing their IEP's; service delivery options; intervention techniques, resource materials for teaching skills in all developmental domains; developing the use of the senses; adapting the regular preschool curricula, schedule and environment to better meet the needs of this population; dealing with behaviors unique to this population; socialization; school readiness; compensatory skill training (i.e., prebraille, orientation and mobility, listening); utilizing support services and other resources in the state; selection of and transition to the elementary school setting.

The VIISA project also collected a variety of data from the participants, instructors, and contact people in each of the nine states in order to help evaluate the effectiveness of the project over the three-year period. Overall, the courses, materials, and VIISA instructors were evaluated quite highly by the participants. A summary of this data can be found in the evaluation section of this report, starting on page 17.

The primary text that has been used with both courses is a two-volume, 1,200 page resource manual for early intervention and early childhood personnel working with children who are blind and visually impaired. It was developed by the SKI-HI Institute at Utah State University from 1990-1992 with the help of a variety of professionals from across the nation who have worked with this age and disability group. This manual underwent some revisions and update in the fall of 1994. This manual has sections that deal with the topics listed on the next page (See Appendix B, Text for the VIISA courses):

The preschool-aged child with vision impairment: characteristics, needs, parent concerns
Working with families: siblings, fathers, resolving conflicts, communication styles, grieving process
Support services: accessing and working with occupational, physical and speech therapists, orientation and mobility specialists, vision services, nurses
Guidelines for family-centered home intervention: information gathering, developmental assessment, IFSP, planning home visits
Transition from home to preschool and preschool to school
Working with children in center-based preschool programs: classroom space, aides, materials, equipment, special techniques, creative exploration, independence, socialization, parent involvement

The manual also contains major units filled with many information lessons with activities in the following areas:

Communication, Language, and Social Skills
Gross Motor and Orientation and Mobility
Learning Through the Senses (Vision, Tactile/Braille Readiness, and Listening)
Childcare and Self-Care
Cognition

VIISA is a cost effective model. Participants take a minimal amount of time from their jobs to receive the training because the onsite classes are generally offered over a Friday and Saturday. Assignments and readings are completed at home and many of the practicum assignments can be done with children with visual impairments in their local programs.

Continuation of the VIISA Inservice Model in Eight of the States

Following the offering of the courses in eight of the original nine states, the VIISA project began to work with the main contact people and task forces in these states to help them put together a plan for continuing with the VIISA inservice training model. By the fall of 1994, seven of the states were ready to have VIISA instructors return to train local instructors. The project helped to provide training packages for each of these states.

During this 3-day final onsite visit, the VIISA instructor spent 1/2 day working out final details for training with the state's task force for VIISA as needed. The following 2 1/2 days were then spent training the local instructors and others as appropriate in the implementation of the VIISA training package.

Some of the topics covered in this training session included: strategies and techniques for working with adult learners; VIISA course overviews; practice with reading and grading home study assignments and familiarization with the VIISA grading procedures; familiarization with the VIISA training package (instructor manuals, videos, transparencies, materials); further discussion and planning of "how it will work in the state;" training in teams; use of resources; and specific preparation plans for the first VIISA courses in the state.

Each state received a complimentary set of materials necessary for the VIISA training package and for use by the person and agency coordinating the training efforts as well as by the local instructors. This training package set (value $450) included the following items for both the VIISA infant/toddler and the preschool courses (See Appendixes D and E):

1. The trainer's manual with white copies of transparencies
2. The master for the home study manuals in print and on computer disk
3. Some videos and slides to use in training
4. A master set of the handouts used in the onsite classes
5. A binder of research articles

In the Winter and Spring of 1994, five of these states will be offering the VIISA course on infants and toddlers under the instruction of the best instructors on their training team. All of the states are having two people team teach each course. They will then follow up with the preschool course in the summer and fall. Some of them are having a national VIISA instructor co-teach with their local training team. Others have just requested some consultation from a national VIISA instructor through their first course. In addition to the full courses, two of the states are using their state instructors to provide one day regional mini inservice workshops for a wide variety of people working with this population of children with blindness and visual impairment in the Spring of 1995. The remaining states are still in the process of working their VIISA implementation plans out.

Future of the VIISA Model

In December of 1993, VIISA project staff wrote and submitted a federal grant, applying for funding to move the project into Outreach status. This new outreach grant has been funded, starting October 1994.

The VIISA Outreach Project proposes to work with three new states each year for a total of nine over the three years of outreach funding to develop and implement the VIISA Inservice Training Model for early intervention/early childhood personnel in their states who work with children birth through five who are blind and visually impaired and their families. The outreach project will also provide technical assistance to the states already implementing the model or adaptations of the model.

VIII. Evaluation Findings

Several evaluation strategies were used to obtain effectiveness data for the VIISA Project. Those are described on the next few pages.

Evaluation of Students

The participants were evaluated by using a pre-post self evaluation of their perception of their knowledge and ability in objectives covered by the two inservice courses. The following table displays the results of this evaluation. The N's were smaller than the total number of participants because not everyone completed the forms.

Participant Perception of Knowledge and Skills

Perception of own knowledge			
	Pretest mean	Posttest mean	Change during course
Course 1	2.8	3.7	0.9 N=145
Course 2	3.1	3.6	0.5 N=52
Perception of own ability			
	Pretest mean	Posttest mean	Change during course
Course 1	3.1	3.8	0.6 N=125
Course 2	3.4	3.9	0.5 N=102

The results of the self-perception evaluation shows that overall the participants perceived that they gained both knowledge and skills in the areas of the courses. Overall they gained from 10% to 20% more knowledge and skills. The participants perceived that their knowledge and skills working with young children with vision impairment had increased as a result of these courses. It should also be noted that participants were required to complete seven to eight homestudy assignments and attend all onsite classes.

Participants were also graded through portfolio assessment. The majority of them earned A's, putting a great deal of effort and time into their home study assignments.

Course Evaluation by Participants

The participants completed a course evaluation. A five point scale with one being lowest and five being highest was completed by the students. The results of this evaluation are displayed below and on the next page.

Participant Course Evaluation -- Course 1

	Lowest				Highest
	1	2	3	4	5
Course Content	0	0	9	64	72
Text	0	2	11	51	82
Readings	0	2	8	47	55
Homestudy Assignments	1	5	27	70	40
Portfolios	1	9	28	44	47
Practicum	1	1	22	49	65
Onsite Classes	0	1	15	38	86
Distance Delivery	11	21	38	40	17
Practical Application	1	2	11	50	77
Total	15	43	169	453	5

Participant Course Evaluation -- Course 2

	Lowest 1	2	3	4	Highest 5
Course Content	0	1	1	42	85
Text	0	2	4	39	85
Readings	0	1	9	51	47
Homestudy Assignments	0	3	19	60	47
Portfolios	2	7	23	42	43
Practicum	0	0	8	52	64
Onsite Classes	0	0	5	30	94
Distance Delivery	3	14	24	28	28
Practical Application	0	0	2	45	82
Total	5	28	95	389	575

A large majority of the participants rated all nine of the areas of the course except distance delivery from 4 to 5. Particularly high were the course content, the text, practicum, onsite class, and practical application. The distance delivery aspect was rated lower and was eliminated because the project did not have the budget to make major changes to it such as video teleconferencing. Participants expressed the desire for more onsite time with the instructor and with each other to network.

Six "yes"/"no" questions were asked. The results of the answer to these questions are shown on the next page.

Participant Answers to Yes/No Questions -- Course 1

	# Yes	# No
Course met expectations	139	5
Liked current inservice plan	106	24
Would prefer all onsite sessions	37	93
Would prefer all homestudy	20	105
Would prefer all distance delivery	5	115
The location/facilities were adequate	128	7

Participant Answers to Yes/No Questions -- Course 2

	# Yes	# No
Course met expectations	126	2
Liked current inservice plan	100	21
Would prefer all onsite sessions	35	67
Would prefer all homestudy	9	90
Would prefer all distance delivery	2	82
The location/facilities were adequate	100	4

Most of the participants felt the course met expectations and liked the location of the onsite classes. They prefer the complete inservice plan (onsite classes, homestudy, and distance learning) to any one single component.

The instructors were evaluated using a five point scale with one being the lowest and five the highest. The results are shown on the next page.

Participant Evaluation of Instructor -- Course 1

	Low				High
	1	2	3	4	5
Knowledge	0	0	1	22	123
Preparedness	0	0	3	26	117
Manner of presentation	0	2	19	23	101
Clarity and understanding	0	0	6	36	104
Encouraging participation	0	0	8	21	116
Responsiveness to questions/needs	0	0	4	19	122
Fairness	0	1	3	17	123
Total	0	3	44	164	806

Participant Evaluation of Instructor -- Course 2

	Low				High
	1	2	3	4	5
Knowledge	0	0	0	11	120
Preparedness	0	0	1	14	116
Manner of presentation	0	2	4	20	107
Clarity and understanding	0	0	1	13	117
Encouraging participation	0	0	1	9	121
Responsiveness to questions/needs	0	0	1	7	122
Fairness	0	0	1	9	120
Total	0	0	9	83	823

The participants rated the instructors extremely high. The low ratings (#3 and lower) were insignificant. Overall the participants really liked the instructors and how they taught.

Evaluation by State Lead Agencies

A state lead agency representative completes an evaluation of the VIISA courses and the impact on the state after the second course has been completed. The evaluation instrument used a five point scale with 1 being lowest and 5 being highest. Yes, no questions were also asked. The results of eight of the state lead agency evaluations of VIISA are shown below and on the next page.

State Lead Agency Five Point Scale Evaluation of Project VIISA

	Low				High
	1	2	3	4	5
1. This project made an effort to coordinate all activities with Staff Office.	0	0	0	1	7
2. The State Office was provided with complete information about the project activities in the State.	0	0	0	1	7
3. Overall this course meets or will meet the State's needs in training early intervention personnel to serve children who are visually impaired in family-centered home-based and center-based programs.	0	0	3	3	2
4. My overall satisfaction with the VIISA Project in our state.	0	0	0	3	5
5. My perception of the impact of the project in our state.	0	0	1	3	5
Total	0	0	4	11	21

State Lead Agency Response to Project VIISA ''Yes''/''No'' Questions

	Yes	Not Working On It At This Time
1. Approval from the project to provide services in the State was given.	8	0
2. The State Office was involved in the selection of participants, site for classes, date, and other operational plans.	8	0
3. The State Office contact was invited to participate in the courses.	8	0
4. The courses can be used toward certification in our state.	4	4
5. I was notified of the participants who completed each course.	8	0
6. Plans are made for providing an in-state trainer upon completion of the courses.	7	1
7. Our office will coordinate and broker future courses using the support of the SKI-HI Institute and the instate instructors.	8	0

All the states rated most of the VIISA services #4 and #5. VIISA received approval to provide services, involved the state office in selection of participants, and notified them of participants who completed the course. Four of the states indicate VIISA training can be used toward certification at this time. Others are working on it. A few comments by state lead agency personnel are provided:

*''This has been very beneficial to our state.''

*''We were pleased with the practical information about visual impairment.''

*''Excellent flexibility to meet individual needs. Excellent manual.''

*''The trainer was well prepared and provided excellent information.''

*"I feel that VIISA has helped our state get on track. I really want to see universities within our state offer VIISA or similar classes on a regular basis."

*"We will have trained close to 300 participants in the VIISA one-day workshops by May 1995. The satisfaction level is high so far in these trainings and many are requesting further information about the full semester long course. Our next problem is how to meet that need with space for only 25 per class."

The achievement of the participants, the high ratings of the course, and the instructors by the participants, and the high evaluations by the state lead agencies all demonstrate the high quality of the courses and the instructors and the overall VIISA program.

Follow-Up Survey From VIISA Participants

At the end of the VIISA Model Demonstration Grant, a follow-up questionnaire was mailed to those who participated in both courses (200) in each of the nine states. As of January 30, 1995, 109 have been received back. For most, this questionnaire came over a year after they had completed their VIISA courses. (See Appendix H for summaries.) Overall, participants have expressed that they have been using the materials, knowledge, and skills gained from their training sessions with, on the average, 3 youngsters (birth to age five) who are blind or visually impaired on their caseloads. Half of these children have additional disabilities. They feel that the training has helped them to better serve these children and their families. They also expressed the desire to come back together at least once a year for a day at a central location as a group for updated information as well as to share and gain new ideas for working with this population of children from each other. All of this feedback will be shared with their state contact and task force for VIISA. The project will work with them to find a way to meet this need for VIISA follow-up in their state. The one area participants expressed a desire to see more of in the VIISA courses are strategies and information on working with children with vision impairment and multiple disabilities.

Evaluation of Local Instructor Training Sessions

In the Fall of 1994, 45 people participated in the state instructor training sessions in eight of the nine states. Overall, these participants responded positively to this 3-day training session. They were very impressed with the instructor manuals and materials and felt much better prepared for teaching the courses. A summary of their comments by state is found in Appendix F. These groups also expressed a need for follow-up, once they had had a chance to first teach the VIISA material. This follow-up may be done through phone conferencing and if possible, an onsite visit by a national VIISA instructor through technical assistance in the new VIISA Outreach grant.

IX. Project Impact

A. State-of-the-Art Materials

The VIISA Project has developed and produced a variety of materials for use in training early intervention/childhood professionals in working with infants, toddlers, and preschoolers who are blind and visually impaired and their families. These materials have been developed, published, and distributed by the VIISA Project at the SKI-HI Institute and HOPE, Inc. in Logan, Utah.

To assist the reader in understanding the evolution of Project VIISA in maintaining a state-of-the-art level of proficiency, a chronology of innovations, developments, and revisions is presented.

1990-92

Development, writing, printing, distribution of first edition of the two-volume, 1,200 page text for the VIISA courses, *Resources for Family-Centered Intervention for Infants, Toddlers, and Preschoolers Who Are Visually Impaired.*

1992-93

First meeting of all VIISA staff and instructors in Logan, Utah, January, 1992.

Development, writing, and field testing of Instructor Manual and Home Study Manual for the VIISA course on Infants and Toddlers and the VIISA course on Preschoolers. Production of the following videos: *Teaching Self-Care Skills in the Context of the Daily Preschool Routine* and *Case Study of a Child Who is Totally Blind in an Integrated Preschool Setting: Quinn.*

1992-94

Conducting VIISA course #1 in nine states and course #2 in ten states for 355 participants, 200 of whom took both courses.

1993-94

Production of following videos: *Functional Vision Assessment of an Infant/Toddler, Functional Vision Assessment of a Preschooler, Infant/Toddler Case Study: Isaac, Case Study of a Child with Low Vision in an Integrated Preschool: Morgan.* Writing of VIISA Outreach Grant to EEPCD. Funded for October 1994-

October 1997. Writing and distribution of VIISA Management manual to the model demonstration states. Second meeting of all VIISA staff and instructors in Logan, Utah, April 1994. Final revisions, packaging, and distribution of Instructor and Home Study Manuals for both VIISA courses for demonstration sites. Using the above materials to train 45 state instructors in eight states to continue VIISA training in the demonstration sites.

Revision of the text, making the second edition (©1995) of *Resources for Family-Centered Intervention for Infants, Toddlers, and Preschoolers Who are Visually Impaired.*

Preparations for start-up of the new VIISA Outreach Grant.

The VIISA project is a growing, changing model that is concerned with services to families of young children with blindness and visual impairment. A constant effort is maintained to ensure that the model represents the latest research and best practice in the field.

In addition to the publications listed above, project VIISA contributes to the SKI-HI Institute newsletter that goes out to VIISA, INSITE, and SKI-HI users throughout the country three times a year.

VIISA also contributes to the biannual "Trainer's Tidings" that is mailed to all local and national VIISA, INSITE, and SKI-HI trainers/instructors across the country.

B. Summary of VIISA Activities

VIISA also assists with the annual survey that goes to replication sites and programs around the country. That information, along with data kept at the project office provide the information needed for the VIISA fact sheet found on the next page. These reflect the impact VIISA has had over the last three years.

Summary of Impact of VIISA Activities 1991-94

	National
Dissemination of information to state agencies	50
Number of VIISA courses, Infant/Toddler, taught in states	9
Number of VIISA courses, Preschoolers, taught in states	10
Number of participants completing Course #1	170
Number of participants completing Course #2	174
Number of Children estimated to benefit from training participants received from the VIISA courses	at least 400, as many as 600
Consultative assistance to sites	10
Instructor workshops to certify new state trainers	7
Number of new state instructors certified and receiving training materials	45
National staff meetings for update, retraining, and revision of training packages	2
Number of national VIISA instructors	6

X. Future Activities

A. Training, Impact on Professionals, Programs, and Families, Assistance to Sites

Project VIISA wrote a grant application for a new 3-year period (1994-97) through OSEP-EEPCD and has been funded to continue as a new Outreach project with new states and programs around the country as well as to provide technical assistance to the demonstration sites. This will also enable the project to develop new training and curricular material as needed.

Through this VIISA Outreach grant, the following impact would be expected.

1. At least six VIISA courses would be conducted each year in three states for a total of 18 courses over the 3-year grant period resulting in a total of 360 professionals trained. Each of these is projected to serve at least two children with the VIISA material, impacting 720 children and their families.
2. VIISA will continue to grow and expand in most of the nine states where training has taken place. The project's impact will begin to develop in at least nine new states.
3. Nine new sites will be provided with the VIISA training package and assisted in implementing the VIISA inservice training model.
4. Around 45 new state instructors will be trained through the state instructor training workshops conducted in the nine new states. A new national instructor will be added to the project.
5. The Project will participate in regional INSITE/SKI-HI/VIISA workshops in several locations around the country.
6. Technical assistance can continue to be provided to the nine demonstration states.

B. New Products and Materials

Through this new grant, the following materials would be developed for VIISA users in the field.

1. Updated course manuals, videoclips, and home study manuals for use in VIISA courses.
2. Updated management manuals.
3. Three yearly newsletters to go out to over 2,000 professionals in the VIISA/SKI-HI/INSITE network.
4. Two yearly "Trainers' Tidings" to go out to all national and local trainers and instructors.
5. A VIISA audiovisual awareness overview and brochure for use in awareness and dissemination.
6. Update information for instructors and trainees on research and best practice approaches to use with this population of young children with blindness and visual impairment.
7. A new monograph for teachers in center-based settings on working with preschoolers with vision impairment in those settings.

XI. Assurance Statement

VIISA confirms that the full text of this report is being sent to ERIC and that copies of the title page, overview, and summary have been sent to the others addressed on the attached sheet.

APPENDIXES

APPENDIX A

VIISA Brochure

assessment and attendance/participation at the two onsite classes. The onsite sessions include use of lecture/discussion, video, small group work, observation, practical experiences and exposure to resource materials, personnel, and agencies in their state that serve young children with blindness and visual impairment.

Modifications to this training format can be made with approval from the VIISA Project (i.e., reducing the number of home study assignments and increasing class time).

WHO CAN TAKE THE VIISA TRAINING?

Approximately twenty-five persons at a time are selected to take each course. Priority is given to early interventionists, early childhood specialists, and vision personnel presently working with an infant, toddler, or preschooler who is visually impaired in an early intervention or preschool program. These individuals must have need for the training.

WHAT ARE THE COSTS?

Project VIISA covers the cost of the National Site Coordinator/Instructors' time but shares their travel expenses with the state. Students purchase the text and pay a registration fee for each course (fees will vary between states). VIISA explores with the state office and/or the LEA the availability of funds to help students with the cost of the text, and travel/lodging for the onsite classes. The state covers the costs of the state instructors.

CAN I RECEIVE CREDIT?

VIISA works with the state departments to see if the courses can be used for continuing eduction credits. The Project also encourages the state to explore ways to offer college credit for the course work.

PROJECT STAFF AND INSTRUCTORS

Elizabeth Morgan at the SKI-HI Institute is Director of the VIISA Project. A National VIISA Instructor is assigned to work with each state. These individuals are educators experienced and certified in working with young children who are blind and visually impaired. They developed and taught the two course series in the 9 demonstration states and trained the new state instructors for VIISA in each of these states.

Irene Topor, Ph.D., University of Arizona, Tucson
Deborah Gleason, M.Ed., Perkins School for the Blind
Lois Hammett, M.Ed., Tennessee Infant Parent Services, Department of Education
Tanni Anthony, Ed.S., Colorado State Department of Education
Elizabeth Morgan, M.Ed., SKI-HI Institute
Sheri Moore, Ph.D., University of Louisville, KY

STATE AGENCY COORDINATION

The VIISA Project inservice training activities are coordinated through a task force made up of representatives from early intervention (Part H, early childhood (Part B), CSPD, and preschool vision services in each state. They work with the Project to develop and carry out an implementation plan for VIISA in their state. They also contact staff of early intervention, early childhood, vision, and LEA programs in order to identify interested and qualified people to take the course series as well as to identify those programs willing to be practicum sites for VIISA trainees. This task force is also involved in selecting state instructors for VIISA and in making budgetary decisions as it relates to funding, and in planning follow-up activities for VIISA trainees.

A state contact person/agency is assigned to: a) make arrangements for local facilities to be used for the onsite classes; b) mail information and materials to participants; c) manage training materials; and d) work with their state instructors through the VIISA course delivery process.

SKI-HI INSTITUTE

The SKI-HI Institute is located at Utah State University and has been federally funded since 1972. The Institute provides training and technical assistance, develops products for and conducts research in home intervention for infants and preschoolers with sensory impairments and their families. The Institute has developed such projects as SKI-HI Outreach, INSITE Outreach, the Intervener Project for Deaf-Blind, Project REAP, Project VIP, Project RITCH, the Coactive Signing Videotapes, Tactile Signing Project, the Utah Statewide Inservice Training Project for Early Childhood Special Education Personnel, Project AHEAD, and Deaf Mentor, as well as the VIISA Project.

For more information, please contact:

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SKI*HI INSTITUTE
Sensory Impaired Home Intervention

PROJECT VIISA OUTREACHING A NATIONAL INSERVICE TRAINING MODEL FOR PROFESSIONALS WORKING WITH CHILDREN FROM BIRTH THROUGH FIVE WHO ARE BLIND AND VISUALLY IMPAIRED

Funded by the U.S. Department of Education,
Office of Special Education
Early Education Programs for Children with Disabilities
Model Inservice Training Programs

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INTRODUCTION TO THE VIISA PROJECT

The VIISA Outreach Project has been funded for a 3-year period, October 1994 to October 1997 by EEPCD. The purpose of this new Outreach Project is to assist states in implementing the VIISA Inservice Training model through the use of their own state instructors. These state instructors will be trained by a national VIISA instructor. They will be prepared to teach the VIISA courses to professionals in their state needing the training. The VIISA project will work closely with a statewide task force to implement the model in a manner that fits with the state's structure, funding, sources, and needs.

The VIISA Inservice Training Model was developed through an EEPCD model inservice training grant from 1991-1994. Through this first grant, materials and procedures for two courses on working with young children with blindness and visual impairment were developed. Both courses were taught to 344 participants in 9 states over the 3-year period. The courses, materials and VIISA instructors were evaluated quite highly by these participants. During the end of this first grant, project staff went back into 7 of the states to train local instructors and to assist each state in setting up the inservice training model through the use of their own state instructors.

Below are some comments about the VIISA Project from participants and state lead agency personnel.

"Empowerment as a teacher of the visually impaired with restored enthusiasm was personally important to me. It has been so very long since I received valuable professional development in visual impairment at the preschool level."

"This has been very beneficial to our state."

"VIISA has taught me more about vision impairment, gave me ideas to use with children and families, and gave me a network of professionals to call upon."

"Excellent flexibility to meet individual needs. Excellent manual."

TRAINING OF STATE INSTRUCTORS FOR VIISA AND IMPLEMENTATION OF THE INSERVICE MODEL

Early on in the implementation process, the VIISA Project works with the state in selecting teams of professionals with early intervention/childhood and preschool vision background. These individuals are then trained onsite by the project to prepare them for teaching the VIISA courses in their state under the support and supervision of the state's VIISA Task Force. Some of the topics covered in their training session include: strategies for working with adult learners; VIISA course overviews; reading and grading home study assignments; familiarization with the training package; presentation techniques; working in training teams; using resources; and specific preparation plans for their state. The training team is also provided with a complimentary set of the VIISA training package material produced by the project (i.e., instructor manuals, some videos, masters of home study manuals, transparencies, and handouts).

Following this initial training, the national VIISA instructor works closely with the state instructors and task force as they prepare to conduct the first VIISA courses in the state. The national VIISA instructor returns onsite to co-teach the first onsite class session with the state instructors so as to provide support and feedback as needed on home study assignments as well as on the onsite class teaching. Following that first onsite, together they will plan the type of assistance needed by the state training team through the remainder of the first course. As needed, a similar process may be followed for the second course.

Once both courses have been taught by the state training teams, the project will provide ongoing technical assistance as needed to these teams and the task force as they continue with implementation of the VIISA inservice model.

COURSE DESCRIPTIONS

The first VIISA course focuses on working with infants and toddlers with blindness and visual impairments in home-based programs and the second focuses on working with these same types of children, ages 3-5 in center-based preschools. Both courses focus on the specialized learning needs of this population and concerns of their families.

First Course

Early Intervention for Infants and Toddlers with Blindness and Vision Impairment and Their Families

This course covers: Unique needs of infants and toddlers who are blind and visually impaired and their families; working with families; observation, assessment, and developing the IFSP; service delivery options; support services needed; intervention techniques, resource materials to use in all developmental domains; developing the use of the senses - vision, touch and hearing; special needs of infants and toddlers with vision impairment; prematurity/additional disabilities; and transitioning issues.

Second Course

Serving Preschoolers (3-5) with Vision Impairment in Center-Based Settings

The course covers: Unique needs of preschoolers who are blind and visually impaired; observation, assessment and developing their IEPs; service delivery options; intervention techniques, and resource materials for teaching skills in all developmental domains; developing the use of the sense; adapting the regular preschool curricula, schedule and environment to better meet the needs of this population; dealing with behaviors unique to this population; socialization; school readiness; compensatory skill training (i.e., prebraille, orientation and mobility, listening); utilizing support services and other resources in the state; selection of and transition to the elementary school setting; and preschoolers with vision impairment and additional disabilities.

COURSE MATERIAL

Participants are exposed to a variety of resources available for use with this population. The primary text is the two-volume *Resources For Family Centered Intervention For Infants, Toddlers, And Preschoolers Who Are Blind and Visually Impaired (1994)* developed through the SKI-HI Institute (1,200 page, two-volume manual, $90 + 10% S&H, available through HOPE Inc., Logan, UT, 801-752-9533). The Home Study Manual with assignments and additional readings is provided with the course.

HOW AND WHERE ARE THE COURSES TAUGHT?

Each course is taught over an 11-13 week period and consists of: 1) An initial two-day onsite class at a central location in the state; 2) Seven home study units with readings and assignments to be mailed to the instructor(s). Some of these involve observations and hands-on experiences with young children who are visually impaired in their own local programs; and 3) A final two-day onsite class. Student grading is based on portfolio

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APPENDIX B

Text for the VIISA Courses

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Sample Pages

Resources for Family Centered Intervention for Infants, Toddlers, and Preschoolers Who Are Visually Impaired

VIISA Project

Volume I

Editor: Elizabeth C. Morgan, M.A

SKI-HI Institute
Utah State University
Logan, Utah

RESOURCES FOR FAMILY-CENTERED INTERVENTION FOR INFANTS, TODDLERS, AND PRESCHOOLERS WHO ARE VISUALLY IMPAIRED

VIISA PROJECT

VOLUME I

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OVERVIEW OF VOLUME I

This volume is divided into seven sections. The first is an introduction which includes some general information on who children with visual impairments are and what their basic needs are.

The second contains information for the early intervention/childhood specialist about working with families and includes information about such topics as the grieving process, family systems, siblings and the special concerns of parents whose children are visually impaired.

The third contains information on support services and resources for both families and professionals.

The fourth contains information on how to implement an early intervention program for children from birth to age three.

The fifth contains information on transitioning and educational placement.

The sixth contains information on serving children with visual impairments, ages 3-5, in a center-based preschool program.

The seventh and final section in this volume contains the first two developmental curriculum units of this two-volume resource manual. A summary of the curriculum units follows:

Unit 1: (in volume 1)	Interacting With People provides information and learning activities in the area of communication, language and socialization, thereby enhancing the parent/child relationship and the child's ability to communicate and interact with others in his or her environment appropriately.
Unit 2: (in volume 1)	Childcare And Self-Care provides information and strategies that can be used by parents and caregivers in assisting the child to develop independence in feeding, hygiene, dressing, toileting and a variety of other daily care tasks and routines.
Unit 3: (in volume 2)	Motor, Orientation, And Mobility provides information as well as activities and strategies that will help the child who is visually impaired learn to move about in his or her home and school environment safely and efficiently.
Unit 4: (in volume 2)	Learning Through The Senses provides direction in how to help the child who is visually impaired to use all available sensory information (i.e., vision, hearing, touch, smell, taste) as he or she explores his or her environment. This unit also covers school readiness skills related to reading in print, braille, and aural formats.

Unit 5: (in volume 2) Cognition provides activities and strategies parents and teachers can use to help the child learn to play with a wide variety of toys and materials as well as to learn specific concepts. Math readiness skills are also addressed here. This unit also contains topics for parents on getting their child ready for educational placement.

Each unit consists of introductory material which overviews the unit, explains how to use the sections and topics in the program, and describes specific assessment tools for observation of skills in that area. This introductory material is followed by the actual topics to be shared with families and other caregivers of children with vision impairment. Each topic contains the following parts:

1. Goal
2. Materials
3. Information for Early Intervention/Childhood Specialist
4. Sample Discussion (specific information for the family and other caregivers on this topic)
5. Sample Activities (activities that can be used to teach specific skills in this area)
6. Sample Challenges (things the family can work on with the child during the week as it relates to this topic)
7. Supplemental Information (if needed)
8. Reference and Reading List (as it relates to the topic)

The early intervention/childhood specialist together with the parents and other caregivers choose the topics and skills to be worked on at any given time, whether done at home, in the center-based preschool, or at any other care setting the child happens to be in.

Note: Throughout this manual, the term "children with visual impairment" will be used to refer to children who are blind as well as those with some vision. It is recognized that there can be a wide range of functioning levels within this population and that some of the needs and methodologies for children who are blind can be quite different from that of children with low vision or multiple disabilities. When referring to the professional who will be working closely with families and their infants and toddlers (birth to age 3) the term early intervention specialist will be used. When referring to the professional working with preschoolers ages 3-5 in center-based settings, the term early childhood specialist will be used. In areas where the content of this manual may apply to professionals working birth to age five, the term early intervention/childhood specialist will be used. We realize that there can be cross-over in these individuals' roles and duties.

Resources for Family Centered Intervention for Infants, Toddlers, and Preschoolers Who Are Visually Impaired

VIISA Project

Volume II

Editor: Elizabeth C. Morgan, M.A.

SKI-HI Institute
Utah State University
Logan, Utah

RESOURCES FOR FAMILY-CENTERED INTERVENTION FOR INFANTS, TODDLERS, AND PRESCHOOLERS WHO ARE VISUALLY IMPAIRED

VIISA PROJECT

VOLUME II

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TOPIC 3:
HOW VISION IS AFFECTED

Parent Goal

Parents and other caregivers will know the implications of the child's eye disorder(s), including how the child sees and the treatment recommended for the disorder.

Materials

- Diagrams V-8 through V-15 found at the end of this topic
- Copies of Diagram V-15, in groups of 500 cards, can be purchased from Optometric Extension Program, 2912 South Daimler Street, Santa Anna, CA 92705
- Low vision simulators, one of which is similar to the child's visual impairment. (If the child has both hearing and vision problems, be sure to add earplugs and headphones.)
- A preschool acuity chart

Information for Early Intervention/Childhood Specialist

Because of the importance of this topic, it may be helpful to spend at least a couple of weeks on it. Know ahead of time if the child's ocular disorder has resulted in one or more of the following functional visual problems:

1. Loss of visual acuity--distance and/or near;
2. Loss of visual field;
3. Contrast sensitivity;
4. Oculomotor problems; and/or
5. Visual processing difficulties.

Share the introductory information on the first page of the Sample Discussion. Then go over the information which relates specifically to the child's ocular disorder and apply it to his or her specific situation. For example, if the child has cataracts only, the information on acuity and contrast sensitivity loss may be all that applies. If the child has brain damage with cerebral palsy and a diagnosis of cortical visual impairment with strabismus, the information on processing and oculomotor disorders will be the most applicable.

When doing activities with the vision simulators for the visual acuity and visual field loss, make sure that you have the parents experience several activities. For example, have them:

1. Walk around or find something upon request;
2. Find an item to order out of a catalog, read a book, do a puzzle, or do some handwork; or
3. Pour a cup of milk or brush their teeth.

Instructions for making low vision simulators are found in Appendix B at the end of this section. If the child is also physically impaired, try to simulate a physical disability in some of the activities (e.g., parents can use only one hand, or can have no head control). If the child is also hearing impaired, give a simulated auditory impairment (cotton balls or earplugs may be placed in ears with earphones on top of all of that, or speak very softly or not at all, or use only gestures). When finished with an activity, ask the parents (or caregiver) how it felt and what kinds of things helped or hindered their efforts. Relate their experiences to what it might be like for their child to function with his or her visual impairment.

Sample Discussion

The visual system--the eyes, the optic nerves, and the brain--can be compared to a video system: the video camera, the cable, and the television set (show parents Diagram V-8, "The Eye Compared To a Video System"). Of course this analogy is simplistic since both the visual system and the video system are much more complex than shown in this figure.

Many things can go wrong in either system. For example, if the lens on the video camera is scratched, the image on the T.V. will not come through clearly. If the camera is out of focus, the picture will be blurred. If the cable connecting the video camera and the T.V. is defective, the signal to the T.V. will be weak or absent. Problems within the T.V. itself will also affect the picture on the T.V. All the parts have to be working well together for a clear image to appear on the television screen. In the same way, the eye (which collects information), the optic nerve (which carries it), and the brain (which interprets it) must all work together for good vision to occur.

There are numerous things that can go wrong with parts of the visual system, resulting in hundreds of eye problems such as cataracts, retinopathy of prematurity, or strabismus. Most children with vision impairments have more than one eye problem at the same time, which then affects how they see in many ways.

Most eye problems fall into one or more of five categories used to describe visual loss. These are:

1. Loss of Visual Acuity: The child does not see as clearly as he or she should; images are not sharp.
2. Loss of Visual Field: The area the child can see--above, below, and to the sides of the eyes--is limited when holding his or her head and eyes still; or the child may have islands of vision.

3. Oculomotor Problems: The child has difficulty with moving his or her eyes when fixating, following, and/or scanning objects with his or her eyes.

4. Reduced Contrast Sensitivity: The child is unable to see the relative difference between the lightness and darkness of objects, something like looking at a faded photograph.
5. Problems with Visual Processing: The child's brain is having difficulty making sense out of what he or she is seeing.

Remember, most children with vision impairments have problems in more than one of the above areas. For example, a child with retinopathy of prematurity may have visual acuity, visual field, and contrast sensitivity losses.

We have had a chance to talk a little about your child's eye problems. Today we want to look more closely at how it affects his or her vision.

LOSS OF VISUAL ACUITY

A child who has a loss of visual acuity does not see the world as clearly as he or she should. (Diagram V-9) Let me show you what I mean. (Conduct an activity with several acuity loss simulators, such as 20/200, Light Perception, and No Light Perception. See Appendix B for instructions on how to make or purchase low vision simulators.) As you can see, there are different amounts of loss of visual acuity, and no two children see the world in quite the same way.

There are two types of visual acuity losses--distance and near. If a child has a distance visual acuity loss, distant objects appear blurry. If a child has a near visual acuity loss, near objects appear blurry. A very large number of children who have vision impairments have both losses.

Doctors in the United States usually record visual acuities in what is called Snellen equivalents. Have you heard of the term "20/20 vision?" Well, this is a Snellen equivalent.

(If the child's eye exam resulted in a Snellen acuity measure for the child, use the following explanation. If it did not, do not spend much time on the explanation unless the parents are interested.)

What do these Snellen visual acuity numbers mean? The top number--the first number said, the numerator--tells us how far your child stood from the eye chart when he or she was tested. The bottom number--the second number said, the denominator--tells us what was the smallest line your child was able to read or identify.

These numbers also mean something else. The big "E" at the top of the standard eye chart is a "200-foot" sized letter. This means that a person with normal, or 20/20, vision can read the "E" at 200 feet--2/3 of the length of a football field. A legally blind child with visual acuities of 20/200 could read the "E" at only 20 feet away while the person with normal vision could read the "E" at 200 feet away. Some children with vision impairments have visual acuities of 20/400 or 20/800. This means that they could not stand any further than 10 or 5 feet away to read the big "E." A child's visual acuities may be so poor that the acuities can not be written in numbers. Words like "sees shadows and gross forms" or "sees light" are used.

There are some methods that can be used to get an acuity measurement on babies and children who cannot identify letters or pictures on a chart. These include such testing methods as preferential looking using the Teller Acuity cards, the Bailey Hall Cereal Test, and the STYCARS Test (see Diagram V-16 in Topic 4 of this section). These tools and methods may not be familiar to or used by many eye physicians who have not worked with young children with disabilities. (Note: If parent wants to know more about these, go into the information on them in greater detail.)

It is difficult to measure exact acuities for babies and children who have multiple impairments. That is why you rarely see numbers like 20/100 written on their eye reports. Often there is just a description of what the doctor thinks the child can see.

By careful observations over a period of time, we can get a good idea of what your child sees. For example, does your child seem to recognize you visually? Can the child choose his or her bottle from other bottles of similar shape or color? Does he or she recognize a familiar toy using only his or her eyes?

The causes of loss of visual acuity can vary. The child may be very near or far sighted and even glasses may not be enough to correct his or her vision to normal. For example, the child may have albinism resulting in a macula that never fully developed, so the child does not see clearly enough to read to the 20/20 line. Glasses will not fix the problem. However, he or she may also have a refractive error, which causes him or her to be near sighted as well. If you remember from our previous topic discussions, a refractive error means that the child's eyes are not able to bend light rays appropriately to have the rays focus clearly on the retina at the back of the eye. Glasses can fix that part of the vision loss. Without glasses, the child may have 20/200 vision, but with the glasses, his or her vision may improve to 20/100.

Another cause of acuity loss may be something within the eye that blocks the light rays from reaching the back of the eye. This could be something like cataracts and corneal opacifications--a cloudy lens or cornea. Or else it could be that the retina, particularly the macula, and/or the optic nerve may be damaged or not fully developed. The bottom line is that the brain does not get a clear picture signal.

Surgery does not always fix visual acuity loss either. Sometimes it helps with cataracts and corneal opacifications. Usually, not much can be done about problems in the retina or optic nerve, except surgery for some kinds of retinal detachments or to relieve pressure caused by a tumor or fluid on the optic nerve. We cannot transplant an eye or optic nerve because of the billions of fibers that would have to be correctly reconnected.

In later topics we will have a chance to explore more closely what your child sees and how well he or she sees. We will work on ways to help the child understand and make sense out of the blurs and blobs in his or her world. We will find ways to help make it easier for your child to see, such as making things larger, getting your child closer to objects, adding more color or contrast, and using appropriate lighting.

Common disorders which have associated visual acuity loss are: high refractive errors such as found with children with Down syndrome; cataracts; retinal detachment; ROP; glaucoma; Leber's amaurosis; underdeveloped eye as in microphthalmia; retina, macula, and/or optic nerve hypoplasia; optic nerve atrophy; albinism; and, aniridia. (See Appendix C for descriptions of common ocular disorders with associate functional implications found in young children.)

LOSS OF VISUAL FIELD

A child with a visual field loss is limited in how large of an area he or she can see. Let me show you what I mean. (Have the parents look through a couple of field loss simulators, such as those representing tunnel vision or central field loss. Make sure one of the simulators is a mixed simulator which simulates both the child's field and acuity loss.) As you can see, there are varying degrees of field loss. Most of us can see an area of about 160° to 180° in front, above, below, and to the sides of the eyes while holding both our head and eyes still and looking forward. A child with a visual field of 20° or less in his or her best eye, which is like looking down a tunnel or the tube of a roll of toilet paper, is considered legally blind (Diagram V-10, cont.). The acuity in that eye may or may not be normal. More often than not, it is poor. As you experienced, even with good visual acuity, a severe visual field loss can make reading and just getting around quite difficult. Some children have "islands" of vision which might be like looking through Swiss cheese (Diagram V-10). Other children have just the opposite with little "blind spots" scattered around their visual field (Diagram V-10, cont.). If a child has lost his or her central visual fields, or central vision, he or she may have problems with seeing color and fine detail (Diagram V-10, cont.). The child will have to use his or her peripheral visual fields, or side vision, for getting around and seeing things.

It is not uncommon to see the word "scotoma," which means a blind spot or area in which a child does not see (Diagram V-10, cont.). The child has to learn to look around it. When a total loss of half of the visual field occurs, it is called a hemianopsia (Diagram V-10). For example, a child with a left hemianopsia may only see the right half of the highchair tray at one time and may not see the food on the left side of the tray.

It is common to see a child with a central field loss holding his or her head in a different position when looking at people or things. This allows the image of the person or thing to fall on the area of the retina that is giving the child the best vision. This is one way in which the child has learned to compensate for not having a full visual field. Some children with nystagmus (jerky eye movements) may also use a different head posture when looking. This is because of where their "null" point is. This is usually a point in the periphery where they are better able to hold their eyes to decrease the jerky movement, thus giving them a slightly clearer image of what they are looking at.

It is very difficult for doctors to measure a young child's visual fields accurately. Sometimes, the doctor may get only a general idea as to where any field problems may be and where your child sees the best and the worst.

By carefully observing over time your child's behavior when he or she is looking, we can get a good idea as to where your child sees the best. For example, when he or she looks at you or a toy, does he or she have a tendency to look from one side? Does the child bump into things on one side? Does he or she trip over things quite often? Does the child look at you by dropping his or her chin and tilting his or her eyes? If the child utilizes an unusual head and/or eye position when looking or using his or her vision, you and the parents can try to analyze what that means. Begin to talk about the behaviors that indicate where the child might see best. Remember, when the child also has a motor impairment, it may be more difficult to sort out how much of the head and/or eye positioning is due to the visual loss and how much is due to the motor impairment. Talk to the child's physical or occupational therapist to make sure that the head position is not a head or neck problem in need of strengthening.

Visual field losses can be caused by any eye problems that block the light rays from reaching the back of the eyes. These could be things like cataracts and corneal opacifications--a cloudy lens or cornea. More often, a field loss is the result of damage or abnormalities of the retina or optic nerve such as a detached retina, retinitis pigmentosa, or a brain tumor putting pressure on the optic nerve. A field loss does not always mean that the child sees nothing in a particular area. It can mean that vision may be more blurred in that area than in other areas. If there is damage somewhere along the optic nerve tract, doctors can sometimes estimate where it is by looking at how a child's visual fields are affected. (Use Diagram V-11, "Different Problems That Can Be Found in the Optic Nerve Pathway with the Resulting Visual Field Loss," if it would help the parents better understand the child's field loss when damage to the visual pathway or visual cortex is involved. You may need to help orient the parents to this somewhat complex figure to aid in their understanding it.)

Usually, there is very little that can be done medically for a field loss unless the disorder happens to be operable, as in the case when a cataract is removed or part of a retina is reattached. Has your child's doctor discussed any type of treatment that he or she feels would help reduce the severity of your child's visual field loss?

In later topics, we will have a chance to find out more about your child's visual field loss. We will teach him or her some ways to compensate for the loss, such as using search patterns and scanning to piece his or her fragmented views of things into wholes.

[Common disorders that result or could result in field loss are Stargardt's disease (or any other type of macular degeneration), retinitis pigmentosa, retinopathy of prematurity, glaucoma, retina detachments, and tumors putting pressure on portions of the optic nerve tract. See Appendix C for descriptions of specific ocular disorders and their associated functional problems.]

REDUCED CONTRAST SENSITIVITY

A child with reduced contrast sensitivity has difficulty telling the relative difference between the lightness and darkness of whatever he or she is looking at. Everything can appear washed out; it's like looking at a faded photograph (Diagram V-12). This is especially a problem for a child trying to tell things apart that are almost the same color.

Reduced contrast sensitivity can affect how a child perceives the world around him or her visually. It can affect the child's recognizing faces, his or her ability to locate things with his or her eyes, and even his or her posture.

Reduced contrast sensitivity can be the result of reduced visual acuities and visual fields, glare, or even problems in the functioning of the visual cortex at the back of the brain.

Some things can be done to enhance contrast sensitivity such as using sunglasses/filters, changing the amount and/or type of lighting, or other modifications in the environment. (Such modifications will be covered later in Section 2.)

[Virtually all disorders affect contrast sensitivity to one degree or another. Some primary eye care practices and low vision services can assess a child's contrast sensitivity and make specific recommendations on how to utilize or enhance the child's current contrast sensitivity.]

OCULOMOTOR PROBLEMS

A child with oculomotor problems--problems with the muscles of the eyes--has difficulty with coordinated movements of his or her eyes. The child may not use his or her eyes together when looking at or following a moving person or thing. He or she may look with one eye and then the other. As the child watches people or things come in close, one eye may turn in or out, or both eyes may turn in (cross) or out. The child may have trouble following fast moving things such as balls. He or she may lose track of them completely. He or she may have difficulty in reaching for things accurately.

In the case of oculomotor problems, the coordinated way the six muscles that move the eye together stops happening. There are several possible causes for this. The frontal lobe of the brain, which helps control the movements of the muscles that move the eyes, may be damaged. A nerve to one of the muscles may be damaged, thereby paralyzing the muscle. One muscle may be longer or shorter than normal so it may not pull far enough or may pull too far. An eye problem may have decreased the visual acuity in only one eye so much that that eye is no longer able to work equally with the better eye.

Problems caused by the muscles that move the eye not working properly can be very complex and difficult to treat. Some problems are corrected or at least improved with glasses and/or medication, or even surgery. Others might be helped by patching the better eye in order to make the poorer or weaker eye learn to work and become stronger. The younger the child when treatment is provided to correct the imbalance, the better his or her prognosis is for developing improved vision. So it is critical that muscle problems are identified during the infant and toddler years.

In some cases, such as a child with cerebral palsy who has had damage to the frontal lobe of the brain, there may be nothing that can be done. The problem is the brain itself. With children who have other motor impairments, it is often hard to determine how much of the problem is caused by the child's vision problems and how much by the child's motor problems. Again, it may be helpful to consult with the child's OT or PT on this problem.

Often a problem with the eyes not moving together causes the child to see double. The more severely affected eye starts to be used less and less. The information sent to the brain by that eye may start to be ignored by the brain (suppression) in order avoid the double vision. If this goes uncorrected, the child can become amblyopic--or functionally blind--in that eye.

Another oculomotor problem that is present in many children with vision problems is nystagmus. This means the child's eyes move in rhythmic jerks. This movement may be in a side-to-side pattern (horizontal), in a circular pattern (rotary), etc. This is not because the muscles that move the eyes are not working together. It is believed that the normal saccades (movements) of the eye as it fixates become exaggerated in low vision children to the degree that these movements can be observed. Nystagmus sometimes decreases as the child gets older. (If the parents want to know more about this, or it is present in the child, take more time to discuss it.)

[Common terms related to oculomotor problems are strabismus, exotropia, esotropia, alternating exotropia, hypotropia, hypertropia, phoria, and amblyopia. See Diagram V-13, "Normal Gazes," and

Diagram V-14, "Heterotropia or Strabismus." See Appendix C for descriptions of specific ocular disorders.]

PROCESSING PROBLEMS

A child who has had damage to his or her brain and also has a cortical visual impairment has a visual cortex that is having difficulty processing and making sense of the information sent to it by the eyes. Very often, the child has healthy, normal eyes and optic nerves.

Let me give you an idea of what this is like. (Show the parents Diagram V-15, "Vision is More Than 20/20 Eyesight." Ask them if they know what the picture is. Let them hold it in any position they would like. If they cannot figure it out after a few minutes, then point out the features and tell them what it is: a cow. Remind them that they have normal eyes and nerves, but their brain is not making sense of the picture.)

Very early in life, children with visual processing problems function as if they are blind. However, with time, stimulation, and neurological maturation, they often progress. This even happens after four or five years of age. In other words, a baby who appears to be blind, one year later may be looking, reaching, and following toys and faces with his or her eyes. The amount of progress varies from child to child. It will be less if the child has additional problems in the eye or optic nerve. In later topics we will learn about ways to help children who have cortical vision problems make sense out of their world. However, there is very little that can be done for these children medically.

If an eye doctor suspects cortical visual loss and is unable to get any type of visual response from a child with low vision and multiple handicaps, he or she may recommend that the child be given a special electronic test called a VER (Visual Evoked Response). This test may let the doctor know for sure if a breakdown has happened in the child's visual cortex by showing whether or not the visual signals are reaching the visual cortex at the back of the brain. The MRI (magnetic resonance imagery) is another test that may be used to diagnose cortical visual impairment.

Although many children with multiple and severe impairments have cortical vision impairments (CVI), the term is often overused for something we know little about. The visual cortex can be damaged by severe head injuries, an infection like meningitis, prolonged hydrocephalus, and/or a difficult birth with associated oxygen deprivation. In addition, some children are born with underdeveloped or even absent brains. See Appendix B in Vision Section 2 for more information on CVI.

Sample Activities

1. Follow through with the activities in the Sample Discussion (e.g., using low vision simulators, looking at and discussing the confusing picture of the cow, etc.).

2. Together do some brief observations related to determining the child's visual acuity and visual field (if and how the child positions his or her head and eyes, if he or she has an oculomotor problem, etc.).

Sample Challenges

1. Read an article (in a pamphlet or section of a book) about your child's vision impairment. See if you can find out more information about his or her vision problem at the library or from your child's eye doctor. You might also want to write to an organization, such as the one listed below, for more information about your child's vision impairment.

   The National Association for
   Parents of Visually Impaired
   P.O. Box 317
   Watertown, MA 02272-0317

2. I will leave you with the simulator most like your child's vision impairment. Use it off and on throughout the week as you do routine tasks about your home or work - but be careful!. You may even want to spend a whole day wearing it. Again, be careful, and make sure someone else is around in case you need help. We will talk about your experiences next week.
3. Make some informal observations this week of how your child functions with his or her eye problem.

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Diagram V-8

THE EYE COMPARED TO A VIDEO SYSTEM

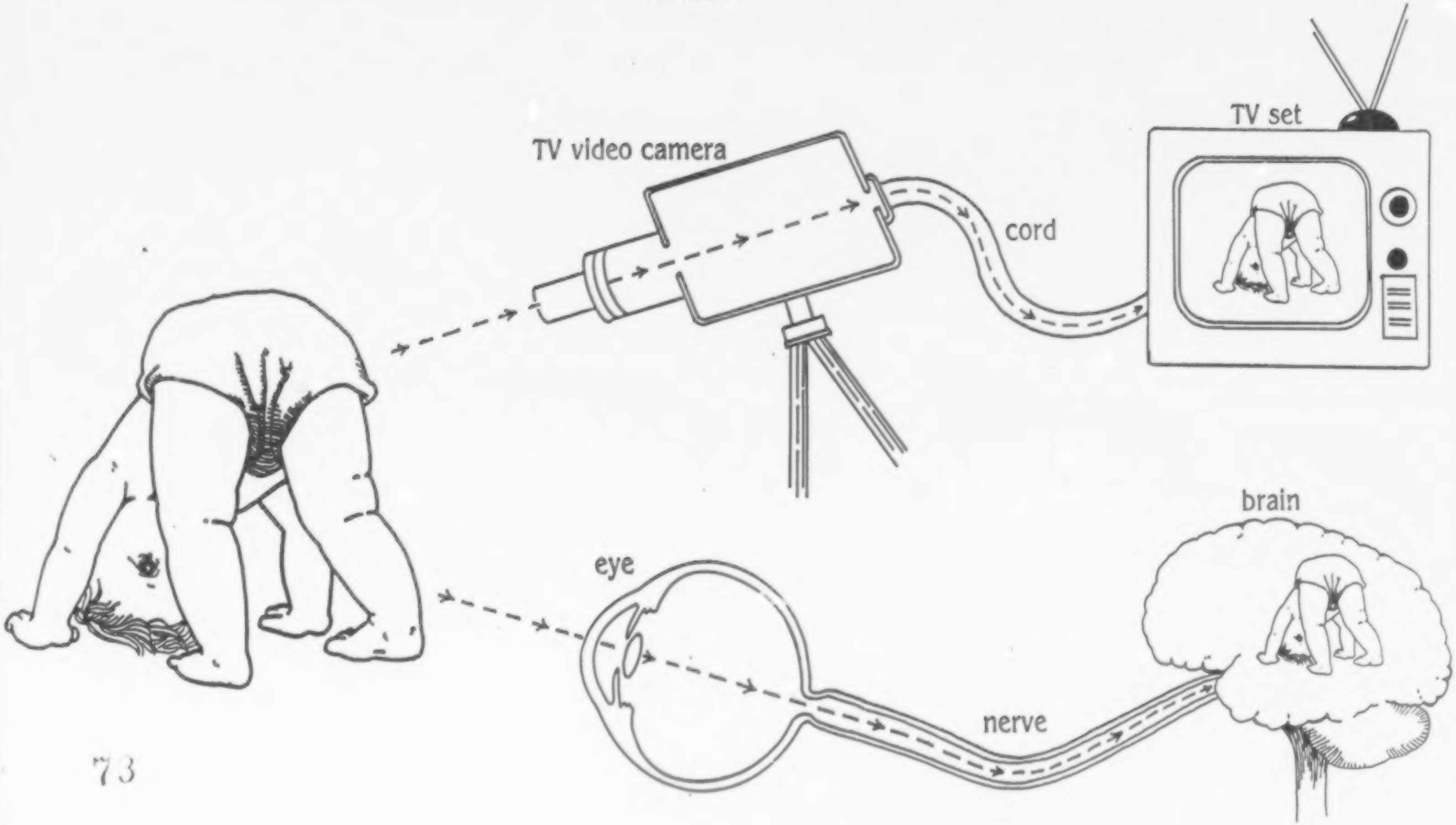


Diagram V-9

HOW VISUAL LOSSES APPEAR

LOSS OF VISUAL ACUITY

Normal visual acuity lets us see sharp details of this house both close up and far away.

The loss of visual acuity causes 'blurry' vision. The child may be able to see the shape of something, but not the details.

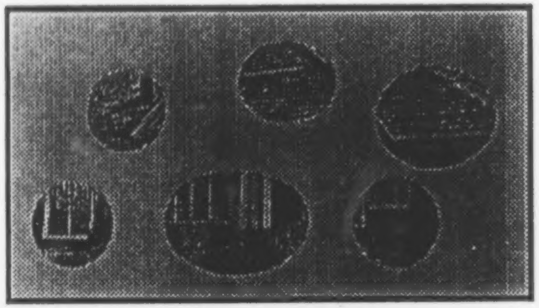
A person has low vision if the acuity in his best eye with the best correction is between 20/50 and 20/200 (AFB).

A person is legally blind if visual acuity is 20/200 or worse in the better eye with the best correction possible.

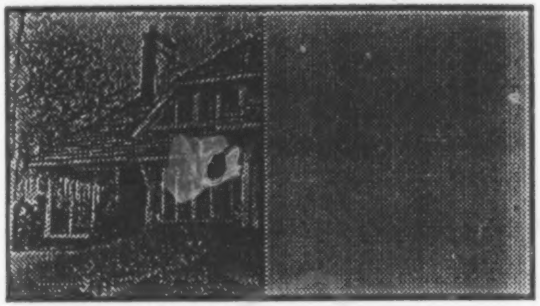
In the U.S., One in 500 people are legally blind.

Diagram V-10

LOSS OF VISUAL FIELDS



'ISLANDS' OF VISION: a child with this type of field loss only sees islolated parts of people or things when he is looking at them. Like with scattered blind spots, the child's functioning will be determined by how big, how many, and where the islands of vision are.



HEMIANOPSIA: A child with this type of field loss only sees half of the people or things when he is looking at them. This half of visual field could be left or right or top or bottom. The child may not notice or bump into people or things 'hidden' in the half of the visual field that has no vision.

A person is legally blind if their visual field is 20° or less in the better eye with the best correction possible.

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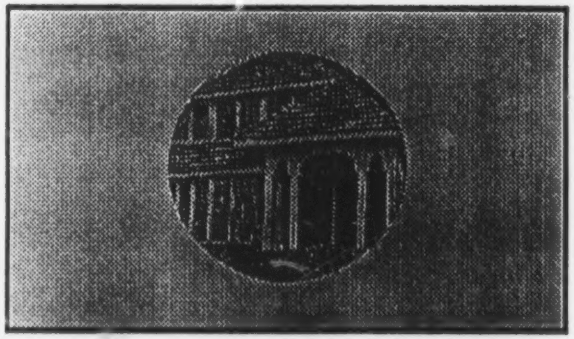
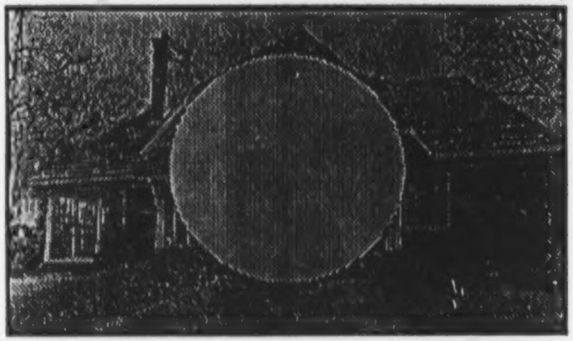
Diagram V-10 (cont.)

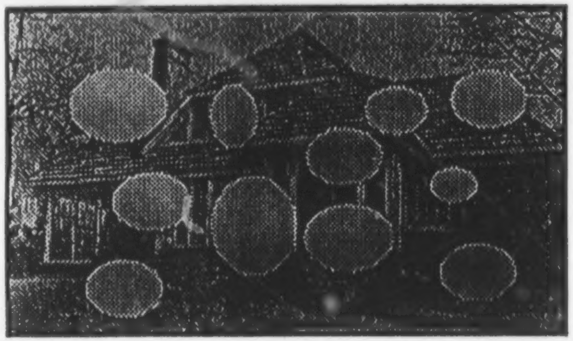
LOSS OF VISUAL FIELDS



LOSS OF PERIPHERAL VISION: A child with this type of field loss will be able to only see straight ahead and will not be able to see people or things at the sides without turning his eyes or head. This is sometimes called tunnel vision. It is like looking through an empty tube of toilet paper.

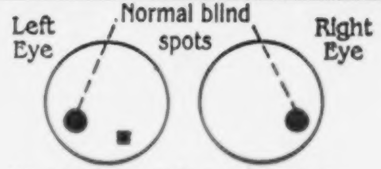


LOSS OF CENTRAL VISION: A child with this type of field loss will only be able to see a blind or grey spot straight ahead no matter which way he turns his eye. It is like looking at a picture with a spot in the middle.

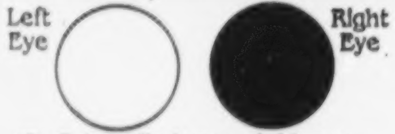


SCATTERED BLIND SPOTS OR SCOTOMAS: A child with this type of field loss may lose 'parts' of people or things when he is looking at them. How big the blind spots are, where they are located, and how many there are, will affect how severe the child's visual functioning will be.

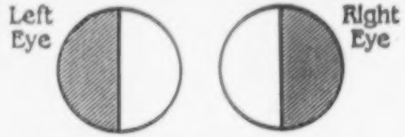
DIFFERENT PROBLEMS THAT CAN BE FOUND IN THE OPTIC NERVE PATHWAY WITH THE RESULTING VISUAL FIELD LOSS



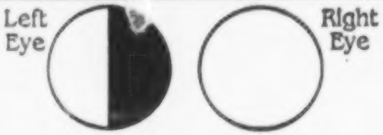
(1) Lesion in left superior temporal retina causes a corresponding field defect in the left inferior nasal visual field.



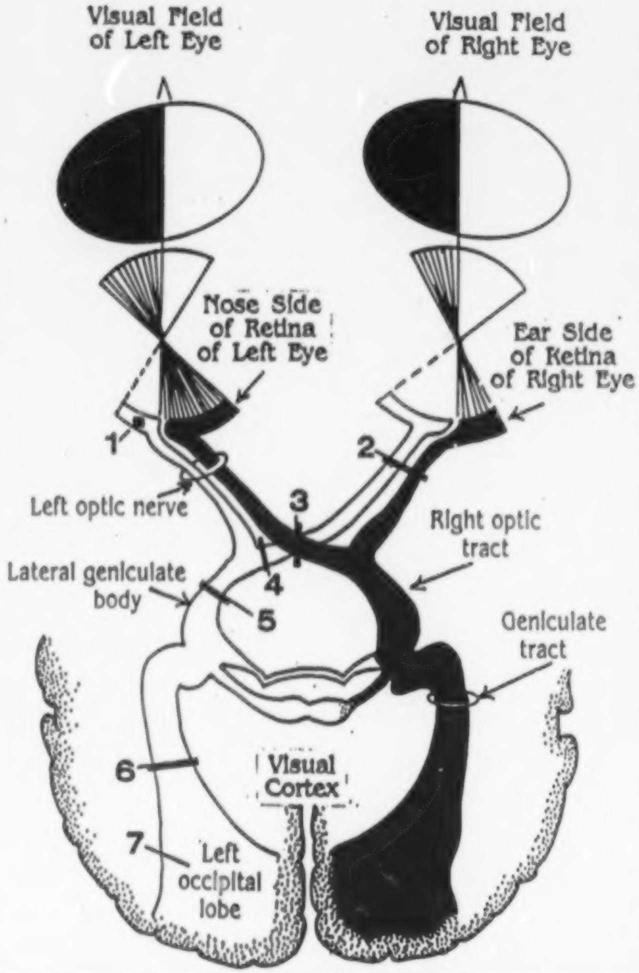
(2) Total blindness, right eye. Complete lesion of right optic nerve.

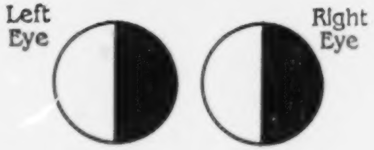


(3) Chiasmal lesion causes bitemporal hemianopsia.

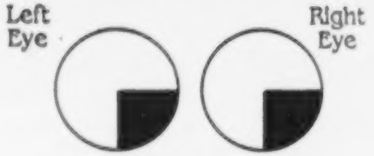


(4) Left nasal hemianopsia due to a lesion involving the outer aspect of one side of the chiasm (pressure on the optic nerve from aneurysm of left internal carotid artery).

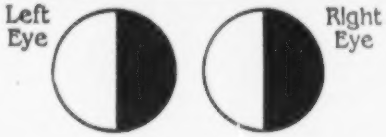




(5) Right homonymous hemianopsia due to a lesion of the left optic tract (least common site of hemianopsia).

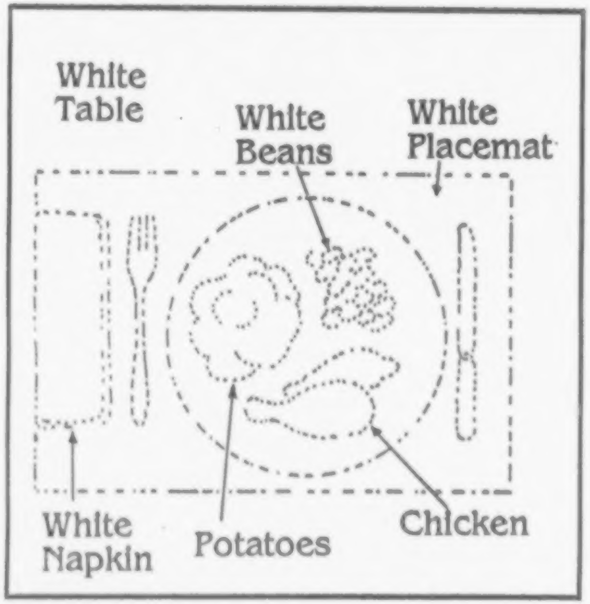


(6) Right homonymous interior quadrantanopsia due to involvement of optic radiations (upper left optic radiation in this case).



(7) Right homonymous hemianopsia due to a lesion of the left occipital lobe. The pupillary light reflex is not impaired.

LOSS OF CONTRAST SENSITIVITY



CONTRAST SENSITIVITY is our ability to tell the difference between the lightness and darkness of things we see. It can also be explained as being able to tell things apart that are almost the same color.

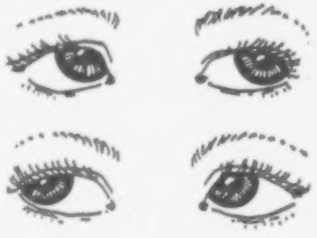
To a child with the loss of contrast sensitivity, everything can appear 'washed out'. It's like looking at a faded photograph.

Diagram V-13

NORMAL GAZES

When you move your eyes straight up, each eye is being pulled by 2 muscles. One moves it up and in; the other moves it up and out. These are the superior rectus and inferior oblique muscles.

When you move your eyes straight down, the two muscles being used on each eye are the inferior rectus and superior oblique.



When you move your eyes up and to the left, the superior rectus and inferior oblique work together. On each eye, one muscle must exert a stronger pull than the other to achieve the turn to the left. In the left eye it is the inferior oblique; in the right eye, it is the superior rectus that pulls harder. The opposite would take place when looking up and to the right.

When you move your eyes to the side, just **one** muscle is exerting a pull on each eye. When looking to the left, the muscles exerting the pull are the external rectus in the left eye and internal rectus in the right eye.

When looking to the right, the internal rectus exerts the pull in the left eye and external rectus exerts the pull in the right eye.

When cross-eyed, the internal rectus in both eyes exerts the pull on each eye.

When looking down and left, the inferior rectus and **superior oblique** exert the pull in the left eye; the **inferior rectus** and superior oblique exert the pull in the right eye (underlined muscle exerts greater pull).

APPENDIX C

VIISA Course Objectives, Home Study Units, and Onsite Class Agendas

#1 Infants and Toddlers

#2 Preschoolers In Center-Based Settings

COURSE OBJECTIVES FOR COURSE ON INFANTS AND TODDLERS

A. Students will gain knowledge of the following as it relates to the needs of infants and toddlers with visual impairment and their families.

1. The effects of visual impairment on child development, learning and behavior.
2. Other disabling conditions which may accompany vision loss.
3. Special needs of premature infants with vision loss.
4. Medical aspects, types and functional implications of specific eye conditions.
5. Visual development.
6. Observation and assessment of functional use of vision and strategies for encouraging functional use of vision.
7. How to encourage use of other senses to compensate for loss of vision (i.e., hearing and tactile).
8. Strategies for enhancing attachment and communication between parent and child.
9. Experiential learning verses manipulative learning.
10. Cognition and problem solving skills.
11. Strategies for developing appropriate social skills.
12. Strategies for developing motor skills.
13. Strategies to use in daily care and for building independence in self-care.
14. Specialized equipment and materials.
15. Assessment methods and tools for use with infants and toddlers who are visually impaired and their families.
16. Resources and services.
17. Appropriate service delivery options for this population.
18. Interaction among familial, cultural, social and physical environments which may influence the young child in achieving optimal growth and development.
19. Transitioning issues.

B. In serving this population, the student will demonstrate the ability to:

1. Work effectively with families and adapt for cultural differences.
2. Develop and implement programs geared to the unique needs and strengths of the child as well as to the family's concerns and priorities.
3. Observe activities and interpret experiences from the infant's and toddler's perspective.
4. Assess the child's level of development, set goals and design learning activities appropriate to the child's level of development in collaboration with the family.
5. Integrate and interpret medical as well as assessment information, explain results to other professionals and parents and generate recommendations for educational programming.
6. Develop an appropriate IFSP with the family and other service providers.

7. Implement, evaluate and adapt learning experiences which address the needs of infants and toddlers with visual impairment.
8. Utilize support people and resources as appropriate (i.e., vision, orientation and mobility, occupational/physical/speech therapy, medical, social worker or counselor, specific agencies) and participate as a team member.
9. Interpret the child's behavior to others as needed.
10. Encourage the use of other senses (i.e., touch, hearing and smell) to compensate for the visual loss.
11. Assess functional vision and facilitate further development of functional visual skills.
12. Design and implement curriculum and teaching strategies for the development and improvement of skills in gross and fine motor, communication, self-care, cognition and concept development, play, social and emotional.
13. Assist in transition from home to center-based preschool setting.

HOME STUDY UNITS FOR COURSE #1

#1 Early Intervention Which Involves the Family

#2 Vision (Medical aspects of vision loss, visual development, assessing functional use of vision and strategies to encourage use of functional vision)

#3 Developing Social-Emotional Skills: Attachment, Communication and Social Behaviors

#4 Childcare Routines

#5 Motor, Orientation and Mobility for the Infant and Toddler

#6 Use of Other Senses to Compensate for Vision Loss (Hearing and Tactile)

#7 Interaction with Objects: Play, Cognition, Concept Development

Topics For Course #1, On-Site #1

- Introduction to Vision Impairment, Video: *Bright Beginnings*
- Experiences Under Total Blindfolds and Low Vision Simulators
- Effects of Vision Loss on Development, Learning, and Behavior
- Current Research and Practices
- Medical Aspects of Vision Loss
- Visual Development
- Contextual Functional Visual Assessment (video case studies)
- Attachment, Communication, and Social
- Working with Families
- Service Delivery Options

Topics For Course #1, On-Site #2

- Gross Motor and Orientation and Mobility
- Child Care Routines
- Use of Touch and Hearing to Compensate for Vision Loss
- Interaction with Objects: Play, Cognition, and Concept Formation
- Child Assessment
- Developing the IFSP
- Infants and Toddlers with Additional Disabilities
- Transition from Home to Center-Based Preschool
- Use of Support People
- Looking Ahead to the Second Course on Preschool

OBJECTIVES FOR COURSE ON PRESCHOOLERS IN-CENTER BASED SETTINGS

A. Students will gain knowledge of the following as it relates to preschoolers with visual impairment and their families.

1. The effects of visual impairment on the development, learning and behavior of the preschooler.
2. The needs of preschoolers with vision loss in the group setting.
3. Curricula, specialized equipment and materials.
4. Assessment methods and tools for use with this population.
5. Assessment of functional vision and methods to encourage further development of functional visual skills.
6. The IEP process and working as a team member.
7. Resources and services for preschoolers.
8. Models of service delivery for preschoolers.
9. Appropriate classroom management skills including use of space, time, instructional methods, materials, curricula, equipment and computer technology.
10. How to adapt each area of the curriculum for early childhood to the unique needs of this population (i.e., art, music play, literature, adaptive behavior, science, movement, social, concepts, language).
11. Methods of instruction for preschool children including physical and sensory stimulation, activity based, experiential, parent mediated...
12. How to help parents remain involved with their child's program.
13. How to encourage independence in the preschooler with vision loss.
14. How to facilitate appropriate social behavior and peer interaction.
15. Compensatory skill areas (i.e., orientation and mobility, braille, listening).
16. Selection and transition to the elementary school setting.
17. Special needs of preschoolers with additional disabilities.

B. In working with this population, the student will demonstrate the ability to:

1. Work effectively with preschoolers who are visually impaired.
2. Develop and implement programs geared to the unique needs of these children in the center-based setting.
3. Work effectively with other team members.
4. Observe activities and interpret experiences from the preschoolers perspective.
5. Assess, set goals and design learning activities appropriate to the child's level, needs, interests and strengths in collaboration with the family and other team members.
6. Integrate and interpret medical as well as assessment information, explain results to other professionals and parents and generate recommendations for educational programming.
7. Develop an appropriate IEP in collaboration with the family and other service providers.
8. Implement, evaluate and adapt learning experiences which address the needs of preschoolers with visual loss.

HOME STUDY UNITS FOR COURSE #2

#1 Introduction to Working with Preschoolers with Vision Loss in the Center-Based Setting

#2 Interacting with People (language, social skills, and play with peers)

#3 Motor; Orientation and Mobility

#4 Cognition and Concept Development

#5 Self-Care and Independence

#6 Use of Functional Vision; Reading Readiness

#7 Braille Readiness and Listening Skills

#8 Assessment and the IEP

Topics For Course #2, On-Site #1

- Introduction to Working with Preschoolers with Vision Impairment in Center-Based Settings
- Interacting with People (Language, Social Skills, and Play)
- Motor; Orientation and Mobility
- Activities of Daily Living
- Preschoolers with Additional Impairments
- Keeping the Family Involved

Topics For Course #2, On-Site #2

- Cognition and Concept Development
- Use of Functional Vision, Reading Readiness
- Braille Readiness and Listening Skills
- Assessment and the IEP
- Choosing the Appropriate Elementary School Placement and Transition Issues
- Wrap-Up and Evaluations

APPENDIX D

VIISA Instructor Manuals

Introduction to Instructors' Manual

Instructor Manual for Course #1

Sample Training Package Guidesheets

Instructor Manual for Course #2

PROJECT VIISA
(Vision Impaired In-Service in America)

A Model Inservice Training Program for Early
Intervention/Early Childhood Professionals Serving
Infants, Toddlers, and Preschoolers Who are Blind and
Visually Impaired

Introduction to the Instructor's Manuals for Both
VIISA Courses

Early Intervention for Infants and Toddlers with Blindness
and Visual Impairment and Their Families

and

Working with Preschoolers with Blindness and Vision
Impairment in Center-Based Settings

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Utah State University
Logan, UT 84322-1900

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Textbook: *Resources for Family Centered Intervention with Infants, Toddlers, and Preschoolers Who Are Blind and Visually Impaired* (1992). Published by the SKI-HI Institute and HOPE, Inc., Logan, Utah.

Note: The terms "instructor" and "trainer" are used interchangeably throughout this manual. Both terms refer to the professional who is conducting or teaching the VIISA classes. The national VIISA instructor who works for the Project based at SKI*HI may also be referred to as a "course consultant".

TABLE OF CONTENTS

VIISA Overview . . . .

State Procedures . . . .

Conducting a VIISA Class . . . .

Appendixes . . . .

Resource Material on Adult Learners. . . . .

Evaluation of Training . . . .

Home Study Manual . . . .

Introduction

This booklet is designed to provide VIISA instructor/trainers with the following:

1. Background information on the VIISA Inservice Training Project.
2. A section in which to place your state's plan for VIISA implementation and your state's procedures for working with instructor/trainers.
3. Ideas on how to prepare for and conduct onsite classes for VIISA.
4. Resource materials and ideas for working with adult learners.
5. Suggestions for reading and grading home study assignments.
6. Guidelines for co-teaching with a National VIISA Instructor/Course Consultant. Some states have decided to go with this teaching model for their first VIISA course series.
7. Evaluation of training.

Companion manuals to this introductory booklet are the Instructor and Home Study Manuals for each VIISA course (i.e., course on infants and toddlers and course on preschoolers.) The Instructor Manuals provide the detailed training packages for the onsite class sessions for both courses. The Home Study Manuals contain course information for the participants, the assignment choices, grading procedures, and additional readings for the class over and above the reading they do in the text. **It is critical that all VIISA instructors/trainers be thoroughly familiar with these materials, prior to teaching a VIISA course.**

In planning for and conducting VIISA training sessions in your state, you will need to work closely with the other instructor/trainers assigned to your training team as well as the lead person/agency assigned by your state's VIISA Coordination Team to coordinate VIISA training. The project has provided them with a Management Manual which gives them some guidelines for planning, implementing, evaluating, and following up on VIISA training sessions. They will need to work out specific procedures for working with, reimbursing, and providing the necessary support for local VIISA instructor/trainers in their state. Printed guidelines that they put together for you can be placed in the second section of this booklet.

The section following this introduction will provide you with some background information on how the VIISA Project came about and an overview of the inservice training model itself.

Good luck with your VIISA classes.

PROJECT VIISA

Trainer's Manual for Course #1

Early Intervention for Infants and Toddlers with Blindness and Visual Impairment and Their Families

SKI-HI Institute
Utah State University
Logan, Utah

Attachment, Communication and Social
(2 hrs.)

OBJECTIVES

A. Participants will identify and develop strategies for enhancing attachment and communication between parent and infant.

B. Participants will identify and develop strategies for developing appropriate social skills.

MATERIALS AND VISUAL AIDS

A. Videos

1. *Communicating with Preverbal Infants and Toddlers*
2. *Infant Temperament*

B. Resource Materials

1. *Dancing cheek to cheek, Talk to me, Talk to me II,* Blind Childrens' Center.
2. *Signs and signals* VORT
3. Overbrook School for the Blind, Parent Early Childhood Series: *Communication 1-5, Stereotypic mannerisms - Prevention and extinction.*
4. Ferrell, K.A. (1985). *Reach out and teach: Parent handbook,* pp. 158-171, "Learning to communicate," pp. 58-60. (Dealing with your child's behavior, pp. 111-112.) (Mannerisms, p. 74.) (What every child needs for good mental health.)
5. *PAVII* (1990). "Assessing infant communication," "Learning together," pp. 12-15. "Learning to listen and to communicate," pp. 10-11 (visual self-stimulation.)
6. Unit One, Chapters 1 and 3 of *Resource Manual for VI.*
7. Article by McConachie, "Early language development and severe visual impairment."

C. Transparencies (These are all in the manual - select only for review of main points and to elicit discussion.)

1. "Matching the Behavioral Style of the Infant with Caregiving Routines"
2. "Identifying Child's Early Communication Signals"
3. "Using Interactive Turn Taking"
4. "Steps to Use in Cuing During Activities and Interactions"
5. "Motherese"

INSTRUCTIONS

A. Introduction (15 minutes) Developing Social-Emotional Skills.

1. Encouraging an emotional bond. A major goal of early intervention is to facilitate an a positive emotional bond between the parent and infant. This first and most important relationship is developed through mutually enjoyable interactions. Intervention strategies are based on the transactional framework which suggests that the characteristics of the infant, parent and environment interact and influence the parent-infant relationship and the infant's development.

   a. Attachment behaviors serve to encourage emotional attachment to a primary caregiver by maintaining closeness to and attracting attention of caregivers. These behaviors include smiling, vocalizing, eye contact, crying and clinging. Attachments to primary caregivers develop at 6-7 months of age after babies can discriminate between people. Fear of strangers will begin at this time and increase until at about 2 years when it declines. Attachments are at their maximum at 12-18 months of age.

      Infants who are visually impaired may have difficulty in developing attachment behaviors for several reasons:

      1. At birth prolonged hospitalization and other medical needs may disrupt the normal bonding process with parents.

      2. A severe visual impairment will limit the infant's access to eye contact, smiles, and familiar faces.

      3. Parents may not be able to engage in consistent, nurturing interactions while dealing with sad and overwhelming feelings.

         According to Erikson, the major psychosocial task of infancy is to develop basic trust. The development of trust and security can be encouraged through regular and sufficient caregiving including feeding, cuddling, and physical contact. Guidelines for observing and promoting parent nurturing on pages 317-323 of the resource manual.

b. **DIFFERENCES IN BEHAVIORAL STYLE (TRANSPARENCY**- use to elicit discussion)

Infants like the rest of us have different temperaments. Temperament refers to our basic dispositions which influence behavior. Some babies seem easy going and responsive, others seem difficult and fussy, while others seem slow to respond. Expression of temperament is influenced by the environment. Research has identified nine qualities of infant temperament and combinations of these qualities which tend to influence an infant's response (Thomas, Chess & Birch, 1970) as discussed in Unit 1, Chapter 3, Topic 2: "Matching the behavioral style of the infant with care-giving routines" pp. 324-327. **(Note: will see video for more detail)**

c. Developing Communication Communication develops through mutually enjoyable parent-infant exchanges. A baby does something and the parent responds. The parent learns to read a baby's behaviors as signals and respond to them.
The baby discovers that he/she can make things happen and before too long he/she can talk!

Research suggests the following strategies facilitate communication development:

1. recognizing early signals
2. establishing turn-taking
3. following the child's lead
4. using repetition
5. labelling key objects and events
6. expanding the child's utterance
7. "upping the ante"
8. establishing play routines
9. providing opportunities for making choices
10. encouraging peer-peer interaction
11. encouraging story telling and explanations

Think about these suggestions as you develop communication strategies for infants and toddlers who are visually impaired.

Discuss how these strategies may be used with a low vision infant and with an infant who is totally blind.

The *Resource Manual* provides a comprehensive series of 17 topics on promoting communication with infants and toddlers who are visually impaired, Unit 1, Chapter 1, "Developing Communication" pp 164-253.

The following is a summary of the main points:

RECOGNIZE EARLY SIGNALS. (TRANSPARENCY) The early signals of a baby with a severe visual impairment may not be easy to interpret. Some signals may be quite subtle or unexpected. For example, the baby may tilt his/her head or become very quiet when trying to listen and then interact. Infants with visual impairments may appear passive and may not initiate or respond to interactions at first. The baby's infrequent smiles, unresponsiveness to facial expressions, and lack of eye contact do not reinforce a parent to continue the interaction.

Parents need encouragement to use touching and vocalization to communicate with the baby and to observe the baby carefully in order to pick up on subtle cues.

Some parents find it helpful to review a videotape of themselves interacting with a baby in natural routine and to identify their baby's communicative behaviors. Some behaviors may indicate a baby's interest in the interaction while others indicate a baby's need to take a break. Other behaviors indicate a baby is happy and comfortable while others indicate hunger or irritability.

USE MOTHERESE. (TRANSPARENCY) Research has revealed that we all speak to babies in a particular way. So called "motherese" attracts the baby's attention and involves a high pitch, repetition, use of short, simple phrases and sentences, exaggerated facial expression and intonation, touching, gestures, and pausing to allow the infant to take a turn. Nonverbal aspects of communication are more meaningful to infants than the actual words. Research indicates that 93% of a parent's message is conveyed to a young child through touch, intonation, gestures, and facial expression. With the baby who is visually impaired we may need to emphasize the nonvisual aspects of "motherese."

MATCH THE INFANT'S COMMUNICATION LEVEL. (TRANSPARENCY)

Progressively matched turn-taking involves imitating what the infant does and adding a bit more. What can you talk about with a baby? Encourage the parent to develop early conversations, games, finger plays with the infant. Conversations must be meaningful to the infant. Topics should involve what's happening immediately, what you are doing together, how he/she is feeling, what he/she is doing.

HELP THE BABY TO UNDERSTAND CUES. (TRANSPARENCY)

A baby who is severely visually impaired needs to understand the following signals as meaningful: intonation patterns, environmental sounds, touch, movement, smell, and texture. First, the baby needs to learn about familiar people, objects, and events. Next, he/she needs to learn that sounds, touch, smell, textures and movements are related to the people, objects, and events that he/she knows. If the baby is low vision, visual cues will be important communication signals. Auditory cues are extremely important and include voice and intonation, sounds made by people and other sounds in the environment. Some totally blind children are startled and upset by sounds that are unpredictable, loud, or confusing. Smells and tastes which are associated with certain activities can be used consistently to help the baby prepare for what is about to happen. Touch and movement are essential ways for communicating with infants who are visually impaired. Babies can pick up messages of affection and attention by how he/she is held and touched. Touch cues can let an infant know what to expect when he/she cannot see what is about to happen and before he/she can understand what is being said. For example, touching the baby's hand before picking up him/her up. In addition, helping the baby to touch objects is another means of communication. For example, helping the baby to touch the bib before putting it on him/her. Parents need encouragement to develop natural opportunities for babies to learn about these sensory cues during everyday routines.

B. Group Activities

1. Attachment (30 mins.)

    a. Select one of the following three options.
    b. For Options 1 and 2 allow 15 minutes for small group discussion and 15 minutes for feedback to large group. Write directions for selected option on chalkboard or large paper.

2. Option 1. Break up into small groups of 4-5 for 15 minutes.

    Directions:
    a. Describe the attachment behavior of a blind or visually impaired infant that you know.
    b. Did this infant show separation anxiety? How?
    c. Develop suggestions for minimizing separation anxiety.
    d. Write list on large paper.

    Feedback from small groups and share suggestions with large group (15 minutes).

3. Option 2. Break up into small groups of 4-5 for 15 minutes.

    Directions:
    a. Read 324-327 on the concept of temperament.
    b. Have you ever known a blind or visually impaired infant who is difficult to care for and another who is easy?
    c. Describe their behaviors.
    d. Develop suggestions for caregivers to create a goodness of fit.
    e. Write list on large paper.

    Feedback from small groups and share suggestions with large group (15 minutes).

4. Option 3. The entire group views the **VIDEO "INFANT TEMPERAMENT".**

    I. **If there is no time to break up into small groups give these directions:** "As you are watching the video, think about one of your infants who is visually impaired. Try to figure out what the baby's temperamental qualities are." Brainstorm strategies for selected babies that people are now working with an having difficulty helping parents to handle well (e.g., a very irritable baby).

II. **If there is time to break up into small groups - divide into groups of 4-5 for**
10 minutes. Directions:

a. Describe the temperamental qualities of infants with visual impairments you have known.

b. What strategies did you develop for working with a "difficult" infant?

c. Think about your own interactive style. How does it fit with the "difficult" or "slow-to-warm" infant. What can we do to "match the infant's interactive style?"

C. Communication (1 hour 15 mins.)

1. The entire group views the **VIDEO "COMMUNICATING WITH PREVERBAL INFANTS AND TODDLERS."** Instructor facilitates discussion on the main points and refers participants to pages in resource manual (e.g. on turn taking). Ask group to identify how strategies might be used with an infant who is totally blind and an infant who is low vision. List adaptations on chalkboard of large paper (40 minutes)

2. Brainstorming and feedback (20 mins.)

a. Write following list on chalkboard or large pad of paper.

b. Break up into small groups (2-3 people) and assign each group one of the following tasks for 10 minutes.

Directions:

a. List ideas for caregivers of a preverbal infant who is visually impaired:

1. Ways to encourage babbling
2. Ways to encourage smiling
3. Ways to encourage turn-taking
4. Ways to comfort a baby
5. When touch cues might be used
6. When object cues might be used
7. When smells might be used as cues
8. When tastes might be used as cues
9. When sounds might be used as cues

Feedback from small groups and share ideas with large group (10 minutes).

3. Directions:

   a. Ask participants to share experiences where social interaction, communication, and attachment issues were difficult.

   b. Brainstorm possible strategies

MATCHING THE BEHAVIORAL STYLE OF THE INFANT WITH CARE GIVING ROUTINES

Quality of Mood

Activity Level

Intensity of Reaction

Threshold of Responsiveness

Attention Span and Persistence

Rhythmicity

Approach-Withdrawal

Distractibility

Adaptability

STEPS TO USE IN CUEING DURING ACTIVITIES AND INTERACTIONS

1. Let your child know you are there.

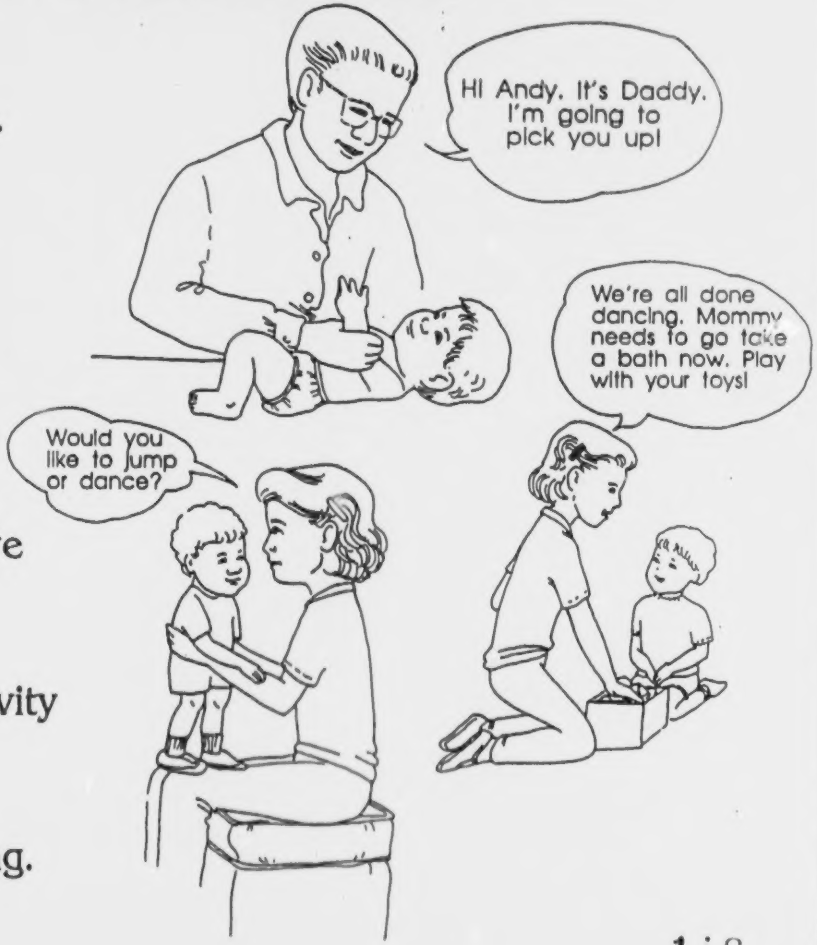
2. Let your child know who you are.

3. Let your child know what you are going to do.

4. Let your child be as independent as possible during the activity. Give him a choice as appropriate.

5. Let your child know when the activity or interaction is over.

6. Let your child know you are leaving.


Hi Andy. It's Daddy. I'm going to pick you up!
We're all done dancing. Mommy needs to go take a bath now. Play with your toys!
Would you like to jump or dance?

MOTHERESE

Motherese involves the use of:

1. Higher pitch
2. Directing communication to child
3. Repitition and (baby words)
4. Pauses and other means to encourage child to take turns
5. Touch and gesture
6. Facial expressions and intonations
7. Short, simple phrases and sentences

Oh! What's that, Stevie? What do you hear?
Arf, Arf!

IDENTIFYING CHILD'S EARLY COMMUNICATION SIGNALS

The infant or child may:

Cry, use facial expressions, gaze

Try to talk babble, vocalize

Touch and grasp

Reach and point

Use movements, gestures

Quiet to Listen

It is important to respond to these early communication signals!

USING INTERACTIVE TURN-TAKING

1. Use activities that involve give and take.

2. Wait for your child to respond.

3. Use a signal to let your child know it is his turn.

4. Imitate your child.

Let's play with the ball now.

5. Change activities if your child isn't interested in what you are doing.

6. Avoid being a turn grabber!

RESOURCE MATERIALS FOR TRAINER

ible 6-1 Nine Characteristics of Infant Temperament Found to Remain Rela-
ely Stable from Infancy Through the Tenth Year of Life

Temperamental Quality	Rating	2 Months	6 Months	1 Year	2 Years	5 Years	10 Years
ivity Level	High	Moves often in sleep. Wriggles when diaper is changed.	Tries to stand in tub and splashes. Bounces in crib. Crawls after dog.	Walks rapidly. Eats eagerly. Climbs into everything.	Climbs furniture. Explores. Gets in and out of bed while being put to sleep.	Leaves table often during meals. Always runs.	Plays ball and eng in other sports. C sit still long enou do homework.
	Low	Does not move when being dressed or during sleep.	Passive in bath. Plays quietly in crib and falls asleep.	Finishes bottle slowly. Goes to sleep easily. Allows nail-cutting without fussing.	Enjoys quiet play with puzzles. Can listen to records for hours.	Takes a long time to dress. Sits quietly on long automobile rides.	Likes chess and re ing. Eats very slo
thmicity	Regular	Has been on four-hour feeding schedule since birth. Regular bowel movement.	Is asleep at 6:30 every night. Awakes at 7:00 A.M. Food intake is constant.	Naps after lunch each day. Always drinks bottle before bed.	Eats a big lunch each day. Always has a snack before bedtime.	Falls asleep when put to bed. Bowel movement regular.	Eats only at meal Sleeps the same amount of time ea night.
	Irregular	Awakes at a different time each morning. Size of feedings varies.	Length of nap varies; so does food intake.	Will not fall asleep for an hour or more. Moves bowels at a different time each day.	Nap time changes from day to day. Toilet training is difficult because bowel movement is unpredictable.	Food intake varies; so does time of bowel movement.	Food intake varies Falls asleep at a di ent time each nigh
actibility	Distractible	Will stop crying for food if rocked. Stops fussing if given pacifier when diaper is being changed.	Stops crying when mother sings. Will remain still while clothing is changed if given a toy.	Cries when face is washed unless it is made into a game.	Will stop tantrum if another activity is suggested.	Can be coaxed out of forbidden activity by being led into something else.	Needs absolute sil for homework. Ha hard time choosin shirt in a store bec they all appeal to
	Not Distractible	Will not stop crying when diaper is changed. Fusses after eating, even if rocked.	Stops crying only after dressing is finished. Cries until given bottle.	Cries when toy is taken away and rejects substitute.	Screams if refused some desired object. Ignores mother's calling.	Seems not to hear if involved in favorite activity. Cries for a long time when hurt.	Can read a book w television set is at volume. Does chor on schedule.
ach rawal	Positive	Smiles and licks washcloth. Has always liked bottle.	Likes new foods. Enjoyed first bath in a large tub. Smiles and gurgles.	Approaches strangers readily. Sleeps well in new surroundings.	Slept well the first time he stayed overnight at grandparents' house.	Entered school building unhesitatingly. Tries new foods.	Went to camp hap Loved to ski the fi time.
	Negative	Rejected cereal the first time. Cries when strangers appear.	Smiles and babbles at strangers. Plays with new toys immediately.	Stiffened when placed on sled. Will not sleep in strange beds.	Avoids strange children in the playground. Whimpers first time at beach. Will not go into water.	Hid behind mother when entering school.	Severely homesick camp during first d. Does not like new activities.
bility	Adaptive	Was passive during first bath; now enjoys bathing. Smiles at nurse.	Used to dislike new foods; now accepts them well.	Was afraid of toy animals at first; now plays with them happily.	Obeys quickly. Stayed contentedly with grandparents for a week.	Hesitated to go to nursery school at first; now goes eagerly. Slept well on camping trip.	Likes camp, althou homesick during fi days. Learns enthus astically.
	Not Adaptive	Still startled by sudden, sharp noise. Resists diapering.	Does not cooperate with dressing. Fusses and cries when left with sitter.	Continues to reject new foods each time they are offered.	Cries and screams each time hair is cut. Disobeys persistently.	Has to be hand-led into classroom each day. Bounces on bed in spite of spankings.	Does not adjust we new school or new teacher; comes hon late for dinner even when punished.

From "The Origin of Personality," by Alexander Thomas, Stella Chess, and Herbert G. Birch.
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contd.

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ble 6-1 *(continued)*

Temperamental Quality	Rating	2 Months	6 Months	1 Year	2 Years	5 Years	10 Years
ntion Span Persistence	Long	If soiled, continues to cry until changed. Repeatedly rejects water if he wants milk.	Watches toy mobile over crib intently. "Coos" frequently.	Plays by self in playpen for more than an hour. Listens to singing for long periods.	Works on a puzzle until it is completed. Watches when shown how to do something.	Practiced riding a two-wheeled bicycle for hours until he mastered it. Spent over an hour reading a book.	Reads for two hours before sleeping. Does homework carefully.
	Short	Cries when awakened but stops almost immediately. Objects only mildly if cereal precedes bottle.	Sucks pacifier for only a few minutes and spits it out.	Loses interest in a toy after a few minutes. Gives up easily if she falls while attempting to walk.	Gives up easily if a toy is hard to use. Asks for help immediately if undressing becomes difficult.	Still cannot tie his shoes because he gives up when he is not successful. Fidgets when parents read to him.	Gets up frequently from homework for a snack. Never finishes a book.
sity action	Intense	Cries when diapers are wet. Rejects food vigorously when satisfied.	Cries loudly at the sound of thunder. Makes sucking movements when vitamins are administered.	Laughs hard when father plays roughly. Screamed and kicked when temperature was taken.	Yells if he feels excitement or delight. Cries loudly if a toy is taken away.	Rushes to greet father. Gets hiccups from laughing hard.	Tears up an entire page of homework if one mistake is made. Slams door of room when teased by younger brother.
	Mild	Does not cry when diapers are wet. Whimpers instead of crying when hungry.	Does not kick often in tub. Does not smile. ~~Screams and kicks~~ when temperature is taken.	Does not fuss much when clothing is pulled on over head.	When another child hit her, she looked surprised, did not hit back.	Drops eyes and remains silent when given a firm parental "No." Does not laugh much.	When a mistake is made in a model airplane, corrects it quietly. Does not comment when reprimanded.
old of nsiveness	Low	Stops sucking on bottle when approached.	Refuses fruit he likes when vitamins are added. Hides head from bright light.	Spits out food he does not like. Giggles when tickled.	Runs to door when father comes home. Must always be tucked tightly into bed.	Always notices when mother puts new dress on for first time. Refuses milk if it is not ice-cold.	Rejects fatty foods. Adjusts shower until water is exactly the right temperature.
	High	Is not startled by loud noises. Takes bottle and breast equally well.	Eats everything. Does not object to diapers being wet or soiled.	Eats food he likes even if mixed with disliked food. Can be left easily with strangers.	Can be left with anyone. Falls asleep easily on either back or stomach.	Does not hear loud, sudden noises when reading. Does not object to injections.	Never complains when sick. Eats all foods.
d	Positive	Smacks lips when first tasting new food. Smiles at parents.	Plays and splashes in bath. Smiles at everyone.	Likes bottle; reaches for it and smiles. Laughs loudly when playing peekaboo.	Plays with sister; laughs and giggles. Smiles when he succeeds in putting shoes on.	Laughs loudly while watching television cartoons. Smiles at everyone.	Enjoys new accomplishments. Laughs when reading a funny passage aloud.
	Negative	Fusses after nursing. Cries when carriage is rocked.	Cries when taken from tub. Cries when given food she does not like.	Cries when given injections. Cries when left alone.	Cries and squirms when given haircut. Cries when mother leaves.	Objects to putting boots on. Cries when frustrated.	Cries when he cannot solve a homework problem. Very "weepy" if he does not get enough sleep.

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care, health and development, 1990, 16, 55–61

Early language development and severe visual impairment

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Accepted for publication 25 May 1989

Summary Some blind children show an early facility with expressive language in advance of their true level of comprehension; children who have severely impaired vision, but use visually-directed reaching, do not. Inspection of developmental assessments of 40 blind and very severely visually impaired children with no other disability, seen at the Wolfson Centre, London, confirmed these patterns. However, a considerable number of blind children showed a lag in expressive speech relative to comprehension, which might mean first words appearing as late as 2 years of age. Later assessments of this group of children showed mixed outcomes. Further prospective research is indicated as a basis for counselling parents.

It has been established by a number of surveys that blind children tend to develop first words later than sighted children do (e.g. Norris *et al.* 1957, Reynell 1978). The content of blind children's early spoken words tends to emphasize people's names and be related to their own body movements. Social phrases may be imitated as a whole and then used in more or less appropriate contexts (Urwin 1983).

This facility with some structures of spoken language may 'outstrip' the attained level of verbal comprehension, if reference is made to the usual relationship between comprehension and expression in sighted children. For example, sighted children may be expected to say their first meaningful word at around the same time as they can make an appropriate response to a simple request (not entirely cued by context) such as 'Show me your tummy' or 'Give me the cup'. A blind child may produce first words 9 months or so before co-operation with requests is well established (Reynell 1979). (Relevant information is presented in Figure 1.)

Raw score	*Verbal Comprehension*			*Expressive Language Structure*		
		Age equivalent (months)		Age equivalent (months)		
		Sighted	Blind	Sighted	Blind	
6	Recognition of familiar sounds	7	10-12	8-9*	8-10	Repetitive double-syllable babble
7	Recognition of familiar words or phrases	8	12-14	10-11	11-14	One definite word
8	Appropriate response to familiar phrase or words	9-10	14-19	12-13	15-18	Expressive jargon
9	Appropriate response to request (e.g. Where is your nose ?)	10-12*	19-22	14-15	19-22	Two-three meaningful words

FIGURE 1. Extract from age equivalent tables for Reynell-Zinkin Developmental Scales for young visually handicapped children. * Sample development levels represented by an expressive lag of 2-3 months (see text).

For severely visually impaired children who have enough vision to show visually-directed reaching for objects on a table, expressive speech has not been found to show this early pattern. Thus, at the stage of jargon and two to four 'situational' words, blind children on average are ahead of the partially-sighted group. When words begin to be true object labels (just past 2 years of age), the partially-sighted begin to show a developmental advantage (Reynell 1978).

However, inspection of average age levels is not indicative for individual patterns of development. In the Developmental Vision Clinic at The Wolfson Centre, London, clinical experience suggested that some blind children were not early talkers and imitators of adult language. Their comprehension would appear to be developing normally, allowing for effects of visual impairment, but they might start to speak only at about 2 years of age. This pattern tended to be worrying for parents alert for signs of intellectual disability in addition to their c[illegible]l's blindness. Late walking and talking are constantly commented on and not understood by relatives and friends.

Therefore, a survey was undertaken of the case records of severely visually impaired children attending the Wolfson Centre who had no other apparent disability, in order to examine further patterns of language development in the second year of life, and later outcome.

SUBJECTS

Eighty-five children were classified on first assessment by a paediatrician as having 'no other disability' from 350 seen in the Developmental Vision Clinic (DVC) between 1973 and 1986. The children are referred from all parts of Greater London and Essex, and additionally many come from other parts of England and Wales.

Of the 85 case records screened, 60 included completed records of assessment between 13 and 24 months of age of children's sensorimotor understanding, verbal comprehension and expressive language structure using the Reynell-Zinkin Developmental Scales for Young Visually Handicapped Children. In each case, the age equivalent of the score for sensorimotor understanding was close to the child's chronological age. The remaining children were either first seen over the age of 2 years, or had incomplete assessment information. (It should be noted that standardized assessment of severely visually impaired children at this age is particularly difficult in that children are often uncooperative with adult requests.)

Of the 60 case records available, 20 of the children had been assessed as totally blind or having minimal light perception. Twenty more were very severely visually impaired (VSVI); visual perception in this group ranged from awareness of a 5-inch dangling object at 10 cm to awareness of a Stycar white ball of 2½-inch diameter at 1 metre distance. (The vision of the remaining 20 children was better, though still severely visually impaired. They will not be discussed further in this paper.) The diagnoses in the blind children included Leber's amaurosis, anophthalmos, microphthalmos, Norrie's disease or other retinal dysplasia, and retrolental fibroplasia. The diagnoses in the VSVI children included optic atrophy, congenital cataracts, albinism, Leber's amaurosis and microphthalmos.

PROCEDURE

The raw scores for assessment of verbal comprehension and expressive nguage structure were related to the age equivalents for sighted ildren (Reynell 1979). By taking the mid-point of the age band presenting any raw score point, the discrepancy between compre-nsion and expression was calculated for each child for assessments rried out between 13 and 24 months. (NB The 'blind' and 'partially-ghted' age equivalents were not used, as the former already reflect e relative advance in some children's spoken language structure at is age. In addition, the inclusion by Reynell of adjusted age levels rived from assessments of children with learning difficulties might fect comparison with the present sample in unknown ways.)

ESULTS

or the blind children, the discrepancy ranged from plus 13 months e. expressive structure ahead in relation to expectations derived om sighted children) to minus 3 months. For the VSVI children, the screpancy ranged from plus 3 to minus 7 months (see Figure 2). Thus, as suggested by other studies, several blind children had pressive performance which seemed greater than their 'real' level of derstanding. For example, the child with the greatest discrepancy ·13 months) was beginning to understand requests to select an object om a choice of three presented, while already regularly using well-rmed sentences of three or more words. Children with some vision ere much more likely to have expressive levels compatible with mprehension, or even lagging behind.

Seven of the blind children showed a lag of 2–3 months in expression lative to comprehension. Although such a lag would not appear of gnificance in a sighted child, it might appear to represent a major lay in a blind child. That is, a blind child would on average be aged –22 months before comprehension is at the stage of making an propriate response to an instruction out of context. At that stage, an pressive lag of 2–3 months (sighted equivalent) would represent pressive speech limited to double-syllable babble with a first real ord yet to appear (see Figure 1, starred entries).

Further information on language comprehension and expression as available from later assessments for 16 of the 20 blind children (in l except one case between 25 and 36 months) (see Figure 3). For four the seven children whose expressive structure had appeared to lag hind comprehension, accelerated development was noted (e.g. from

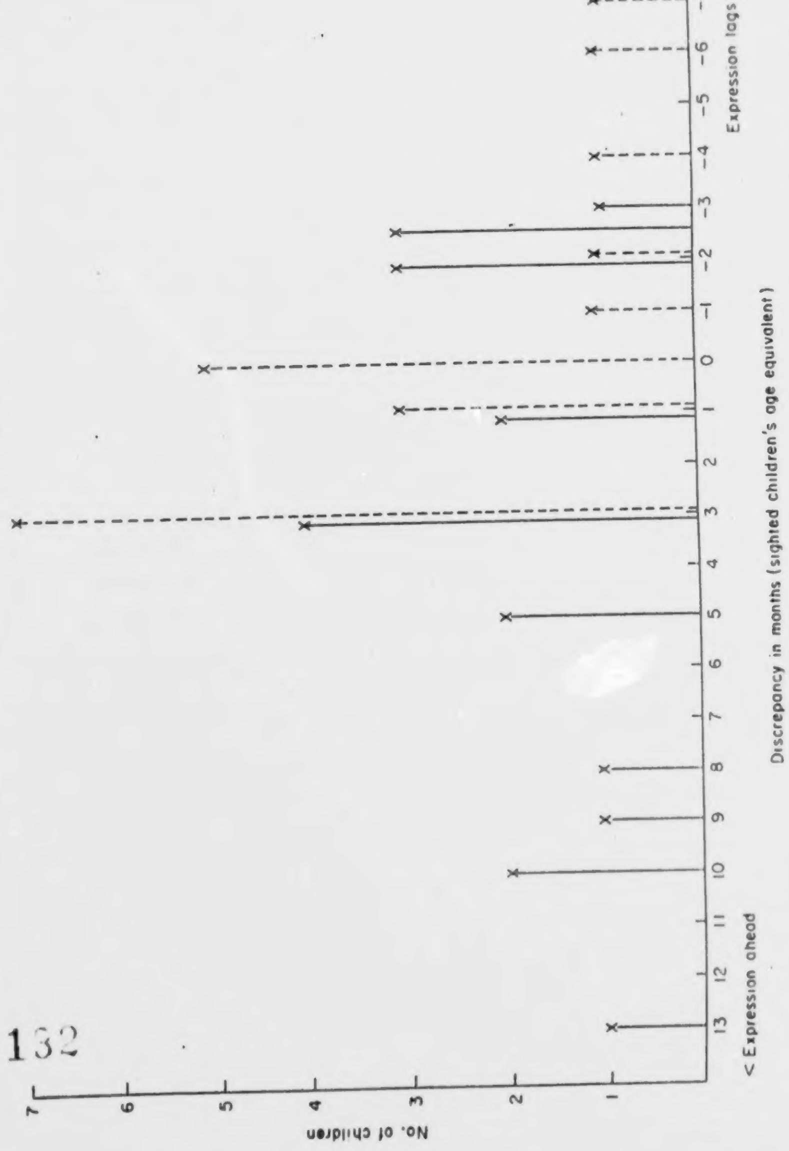

FIGURE 2. Discrepancy between expressive language structure and comprehension on assessment up to 24 months. ——— = blind; -------- = very severely visually impaired.

	At assessment between 13 and 24 months		
At assessment after 2 years	Expression ahead (+13 to +5 months)	Expression = comprehension	Expession lags (−2 to −7 months)
Expression ahead	3	1	2
Expression = comprehension	2	3	2
Severe delay emerges			3

IGURE 3. Later language profile for 16 blind children (R-Z norms).

xpressive jargon to sentences of three or more words in only 7 ıonths). However, in three other children a picture emerged of eneral developmental delay (2) or specific language disorder (1). hese children were not distinguishable from the others by aetilogy, social circumstances, or other early signs from case record ıformation.

Fourteen of the 20 VSVI children were seen for later assessments nitial assessment discrepancy range +3 months to −4 months). All xcept one showed good developmental progress, seven with exressive level apparently in advance of age equivalents for comprehenon. The one child seemed to have a specific expressive delay until atching up' at 3 years 6 months.

ISCUSSION

he language assessment data obtained from case records of 40 hildren with severe visual impairment and no other apparent isability have confirmed the picture described by others. For some lind children, early expressive language structure is in advance of omprehension, in comparison with expectations derived from sighted hildren, and this pattern is not seen in children with a little vision.

However, an equal number of blind children were found to have ome expressive lag at first. Some of these children were noted to be stening intently to their surroundings, and often to remain silent. he outcome on later assessments for these children was mixed.

In order to begin to understand children's varying early patterns, and even to try to predict outcome in counselling parents, much more detailed research is required. For example, it will be important to look prospectively at the context for development of a child's first words. This might include how parents respond to different kinds of cues given by children (cf. Rowland 1984) and the kinds of instructions and descriptions given to children by parents (cf. Kekelis & Andersen 1984). Such analysis would need also to consider how children are enabled to gain active control over their own world (Urwin 1983). The possible significance of early neurological signs would also need to be considered. The author has received a pilot study grant from the Mary Kitzinger Trust in order to study children's variations in emergent expressive language, the content of first words, and the communicative context of play and interaction with parents in the second year of life.

ACKNOWLEDGEMENTS

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PROJECT VIISA

Instructor's Manual for Course #2

Working with Preschoolers with Blindness and Vision Impairment in Center-Based Settings

SKI-HI Institute
Utah State University
Logan, Utah

APPENDIX D

VIISA Instructor Manuals

Introduction to Instructors' Manual

Instructor Manual for Course #1

Sample Training Package Guidesheets

Instructor Manual for Course #2

PROJECT VIISA
(Vision Impaired In-Service in America)

A Model Inservice Training Program for Early
Intervention/Early Childhood Professionals Serving
Infants, Toddlers, and Preschoolers Who are Blind and
Visually Impaired

Introduction to the Instructor's Manuals for Both
VIISA Courses

Early Intervention for Infants and Toddlers with Blindness
and Visual Impairment and Their Families

and

Working with Preschoolers with Blindness and Vision
Impairment in Center-Based Settings

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Utah State University
Logan, UT 84322-1900

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Textbook: *Resources for Family Centered Intervention with Infants, Toddlers, and Preschoolers Who Are Blind and Visually Impaired* (1992). Published by the SKI-HI Institute and HOPE, Inc., Logan, Utah.

Note: The terms "instructor" and "trainer" are used interchangeably throughout this manual. Both terms refer to the professional who is conducting or teaching the VIISA classes. The national VIISA instructor who works for the Project based at SKI*HI may also be referred to as a "course consultant".

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State Procedures . . . .

Conducting a VIISA Class . . . .

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Resource Material on Adult Learners. . . . .

Evaluation of Training . . . .

Home Study Manual . . . .

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Introduction

This booklet is designed to provide VIISA instructor/trainers with the following:

1. Background information on the VIISA Inservice Training Project.
2. A section in which to place your state's plan for VIISA implementation and your state's procedures for working with instructor/trainers.
3. Ideas on how to prepare for and conduct onsite classes for VIISA.
4. Resource materials and ideas for working with adult learners.
5. Suggestions for reading and grading home study assignments.
6. Guidelines for co-teaching with a National VIISA Instructor/Course Consultant. Some states have decided to go with this teaching model for their first VIISA course series.
7. Evaluation of training.

Companion manuals to this introductory booklet are the Instructor and Home Study Manuals for each VIISA course (i.e., course on infants and toddlers and course on preschoolers.) The Instructor Manuals provide the detailed training packages for the onsite class sessions for both courses. The Home Study Manuals contain course information for the participants, the assignment choices, grading procedures, and additional readings for the class over and above the reading they do in the text. It is **critical that all VIISA instructors/trainers be thoroughly familiar with these materials, prior to teaching a VIISA course.**

In planning for and conducting VIISA training sessions in your state, you will need to work closely with the other instructor/trainers assigned to your training team as well as the lead person/agency assigned by your state's VIISA Coordination Team to coordinate VIISA training. The project has provided them with a Management Manual which gives them some guidelines for planning, implementing, evaluating, and following up on VIISA training sessions. They will need to work out specific procedures for working with, reimbursing, and providing the necessary support for local VIISA instructor/trainers in their state. Printed guidelines that they put together for you can be placed in the second section of this booklet.

The section following this introduction will provide you with some background information on how the VIISA Project came about and an overview of the inservice training model itself.

Good luck with your VIISA classes.

PROJECT VIISA

Trainer's Manual for Course #1

Early Intervention for Infants and Toddlers with Blindness
and Visual Impairment and Their Families

SKI-HI Institute
Utah State University
Logan, Utah

Attachment, Communication and Social
(2 hrs.)

OBJECTIVES

A. Participants will identify and develop strategies for enhancing attachment and communication between parent and infant.

B. Participants will identify and develop strategies for developing appropriate social skills.

MATERIALS AND VISUAL AIDS

A. Videos

1. *Communicating with Preverbal Infants and Toddlers*
2. *Infant Temperament*

B. Resource Materials

1. *Dancing cheek to cheek, Talk to me, Talk to me II,* Blind Childrens' Center.
2. *Signs and signals* VORT
3. Overbrook School for the Blind, Parent Early Childhood Series: *Communication 1-5, Stereotypic mannerisms - Prevention and extinction.*
4. Ferrell, K.A. (1985). *Reach out and teach: Parent handbook,* pp. 158-171, "Learning to communicate," pp. 58-60. (Dealing with your child's behavior, pp. 111-112.) (Mannerisms, p. 74.) (What every child needs for good mental health.)
5. *PAVII* (1990). "Assessing infant communication," "Learning together," pp. 12-15. "Learning to listen and to communicate," pp. 10-11 (visual self-stimulation.)
6. Unit One, Chapters 1 and 3 of *Resource Manual for VI.*
7. Article by McConachie, "Early language development and severe visual impairment."

C. Transparencies (These are all in the manual - select only for review of main points and to elicit discussion.)

1. "Matching the Behavioral Style of the Infant with Caregiving Routines"
2. "Identifying Child's Early Communication Signals"
3. "Using Interactive Turn Taking"
4. "Steps to Use in Cuing During Activities and Interactions"
5. "Motherese"

INSTRUCTIONS

A. Introduction (15 minutes) Developing Social-Emotional Skills.

1. Encouraging an emotional bond. A major goal of early intervention is to facilitate an a positive emotional bond between the parent and infant. This first and most important relationship is developed through mutually enjoyable interactions. Intervention strategies are based on the transactional framework which suggests that the characteristics of the infant, parent and environment interact and influence the parent-infant relationship and the infant's development.

   a. Attachment behaviors serve to encourage emotional attachment to a primary caregiver by maintaining closeness to and attracting attention of caregivers. These behaviors include smiling, vocalizing, eye contact, crying and clinging. Attachments to primary caregivers develop at 6-7 months of age after babies can discriminate between people. Fear of strangers will begin at this time and increase until at about 2 years when it declines. Attachments are at their maximum at 12-18 months of age.

      Infants who are visually impaired may have difficulty in developing attachment behaviors for several reasons:

      1. At birth prolonged hospitalization and other medical needs may disrupt the normal bonding process with parents.

      2. A severe visual impairment will limit the infant's access to eye contact, smiles, and familiar faces.

      3. Parents may not be able to engage in consistent, nurturing interactions while dealing with sad and overwhelming feelings.

         According to Erikson, the major psychosocial task of infancy is to develop basic trust. The development of trust and security can be encouraged through regular and sufficient caregiving including feeding, cuddling, and physical contact. Guidelines for observing and promoting parent nurturing on pages 317-323 of the resource manual.

b. **DIFFERENCES IN BEHAVIORAL STYLE** (**TRANSPARENCY**- use to elicit discussion)

Infants like the rest of us have different temperaments. Temperament refers to our basic dispositions which influence behavior. Some babies seem easy going and responsive, others seem difficult and fussy, while others seem slow to respond. Expression of temperament is influenced by the environment. Research has identified nine qualities of infant temperament and combinations of these qualities which tend to influence an infant's response (Thomas, Chess & Birch, 1970) as discussed in Unit 1, Chapter 3, Topic 2: "Matching the behavioral style of the infant with care-giving routines" pp. 324-327. **(Note: will see video for more detail)**

c. Developing Communication Communication develops through mutually enjoyable parent-infant exchanges. A baby does something and the parent responds. The parent learns to read a baby's behaviors as signals and respond to them.
The baby discovers that he/she can make things happen and before too long he/she can talk!

Research suggests the following strategies facilitate communication development:

1. recognizing early signals
2. establishing turn-taking
3. following the child's lead
4. using repetition
5. labelling key objects and events
6. expanding the child's utterance
7. "upping the ante"
8. establishing play routines
9. providing opportunities for making choices
10. encouraging peer-peer interaction
11. encouraging story telling and explanations

Think about these suggestions as you develop communication strategies for infants and toddlers who are visually impaired.

Discuss how these strategies may be used with a low vision infant and with an infant who is totally blind.

The *Resource Manual* provides a comprehensive series of 17 topics on promoting communication with infants and toddlers who are visually - impaired, Unit 1, Chapter 1, "Developing Communication" pp 164-253.

The following is a summary of the main points:

RECOGNIZE EARLY SIGNALS. (TRANSPARENCY)
The early signals of a baby with a severe visual impairment may not be easy to interpret. Some signals may be quite subtle or unexpected. For example, the baby may tilt his/her head or become very quiet when trying to listen and then interact. Infants with visual impairments may appear passive and may not initiate or respond to interactions at first. The baby's infrequent smiles, unresponsiveness to facial expressions, and lack of eye contact do not reinforce a parent to continue the interaction.

Parents need encouragement to use touching and vocalization to communicate with the baby and to observe the baby carefully in order to pick up on subtle cues.

Some parents find it helpful to review a videotape of themselves interacting with a baby in natural routine and to identify their baby's communicative behaviors. Some behaviors may indicate a baby's interest in the interaction while others indicate a baby's need to take a break. Other behaviors indicate a baby is happy and comfortable while others indicate hunger or irritability.

USE MOTHERESE. (TRANSPARENCY)
Research has revealed that we all speak to babies in a particular way. So called "motherese" attracts the baby's attention and involves a high pitch, repetition, use of short, simple phrases and sentences, exaggerated facial expression and intonation, touching, gestures, and pausing to allow the infant to take a turn. Nonverbal aspects of communication are more meaningful to infants than the actual words. Research indicates that 93% of a parent's message is conveyed to a young child through touch, intonation, gestures, and facial expression. With the baby who is visually impaired we may need to emphasize the nonvisual aspects of "motherese."

MATCH THE INFANT'S COMMUNICATION LEVEL. (TRANSPARENCY)

Progressively matched turn-taking involves imitating what the infant does and adding a bit more. What can you talk about with a baby? Encourage the parent to develop early conversations, games, finger plays with the infant. Conversations must be meaningful to the infant. Topics should involve what's happening immediately, what you are doing together, how he/she is feeling, what he/she is doing.

HELP THE BABY TO UNDERSTAND CUES. (TRANSPARENCY)

A baby who is severely visually impaired needs to understand the following signals as meaningful: intonation patterns, environmental sounds, touch, movement, smell, and texture. First, the baby needs to learn about familiar people, objects, and events. Next, he/she needs to learn that sounds, touch, smell, textures and movements are related to the people, objects, and events that he/she knows. If the baby is low vision, visual cues will be important communication signals. Auditory cues are extremely important and include voice and intonation, sounds made by people and other sounds in the environment. Some totally blind children are startled and upset by sounds that are unpredictable, loud, or confusing. Smells and tastes which are associated with certain activities can be used consistently to help the baby prepare for what is about to happen. Touch and movement are essential ways for communicating with infants who are visually impaired. Babies can pick up messages of affection and attention by how he/she is held and touched. Touch cues can let an infant know what to expect when he/she cannot see what is about to happen and before he/she can understand what is being said. For example, touching the baby's hand before picking up him/her up. In addition, helping the baby to touch objects is another means of communication. For example, helping the baby to touch the bib before putting it on him/her. Parents need encouragement to develop natural opportunities for babies to learn about these sensory cues during everyday routines.

B. Group Activities

1. Attachment (30 mins.)

   a. Select one of the following three options.
   b. For Options 1 and 2 allow 15 minutes for small group discussion and 15 minutes for feedback to large group. Write directions for selected option on chalkboard or large paper.

2. Option 1. Break up into small groups of 4-5 for 15 minutes.

   Directions:
   a. Describe the attachment behavior of a blind or visually impaired infant that you know.
   b. Did this infant show separation anxiety? How?
   c. Develop suggestions for minimizing separation anxiety.
   d. Write list on large paper.

   Feedback from small groups and share suggestions with large group (15 minutes).

3. Option 2. Break up into small groups of 4-5 for 15 minutes.

   Directions:
   a. Read 324-327 on the concept of temperament.
   b. Have you ever known a blind or visually impaired infant who is difficult to care for and another who is easy?
   c. Describe their behaviors.
   d. Develop suggestions for caregivers to create a goodness of fit.
   e. Write list on large paper.

   Feedback from small groups and share suggestions with large group (15 minutes).

4. Option 3. The entire group views the **VIDEO "INFANT TEMPERAMENT"**.

   I. **If there is no time to break up into small groups give these directions:** "As you are watching the video, think about one of your infants who is visually impaired. Try to figure out what the baby's temperamental qualities are." Brainstorm strategies for selected babies that people are now working with an having difficulty helping parents to handle well (e.g., a very irritable baby).

II. **If there is time to break up into small groups - divide into groups of 4-5 for**
10 minutes. Directions:

a. Describe the temperamental qualities of infants with visual impairments you have known.

b. What strategies did you develop for working with a "difficult" infant?

c. Think about your own interactive style. How does it fit with the "difficult" or "slow-to-warm" infant. What can we do to "match the infant's interactive style?"

C. Communication (1 hour 15 mins.)

1. The entire group views the **VIDEO "COMMUNICATING WITH PREVERBAL INFANTS AND TODDLERS."** Instructor facilitates discussion on the main points and refers participants to pages in resource manual (e.g. on turn taking). Ask group to identify how strategies might be used with an infant who is totally blind and an infant who is low vision. List adaptations on chalkboard of large paper (40 minutes)

2. Brainstorming and feedback (20 mins.)

a. Write following list on chalkboard or large pad of paper.

b. Break up into small groups (2-3 people) and assign each group one of the following tasks for 10 minutes.

Directions:

a. List ideas for caregivers of a preverbal infant who is visually impaired:

1. Ways to encourage babbling
2. Ways to encourage smiling
3. Ways to encourage turn-taking
4. Ways to comfort a baby
5. When touch cues might be used
6. When object cues might be used
7. When smells might be used as cues
8. When tastes might be used as cues
9. When sounds might be used as cues

Feedback from small groups and share ideas with large group (10 minutes).

3. Directions:

   a. Ask participants to share experiences where social interaction, communication, and attachment issues were difficult.

   b. Brainstorm possible strategies

MATCHING THE BEHAVIORAL STYLE OF THE INFANT WITH CARE GIVING ROUTINES

Quality of Mood

Activity Level

Intensity of Reaction

Threshold of Responsiveness

Attention Span and Persistence

Rhythmicity

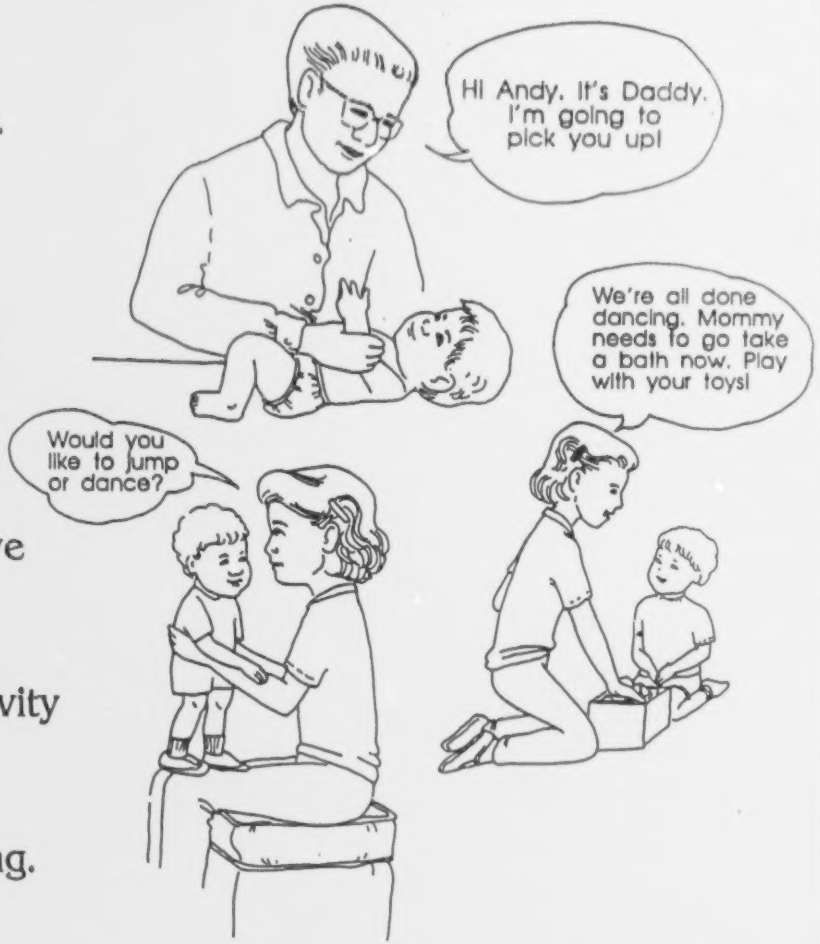
Approach-Withdrawal

Distractibility

Adaptability

STEPS TO USE IN CUEING DURING ACTIVITIES AND INTERACTIONS

1. Let your child know you are there.
2. Let your child know who you are.
3. Let your child know what you are going to do.
4. Let your child be as independent as possible during the activity. Give him a choice as appropriate.
5. Let your child know when the activity or interaction is over.
6. Let your child know you are leaving.


Hi Andy. It's Daddy. I'm going to pick you up!
We're all done dancing. Mommy needs to go take a bath now. Play with your toys!
Would you like to jump or dance?

MOTHERESE

Motherese involves the use of:

1. Higher pitch
2. Directing communication to child
3. Repitition and (baby words)
4. Pauses and other means to encourage child to take turns
5. Touch and gesture
6. Facial expressions and intonations
7. Short, simple phrases and sentences

Oh! What's that, Stevie? What do you hear?
Arf, Arf!

IDENTIFYING CHILD'S EARLY COMMUNICATION SIGNALS

The infant or child may:

Cry, use facial expressions, gaze

Try to talk babble, vocalize

Touch and grasp

Reach and point

Use movements, gestures

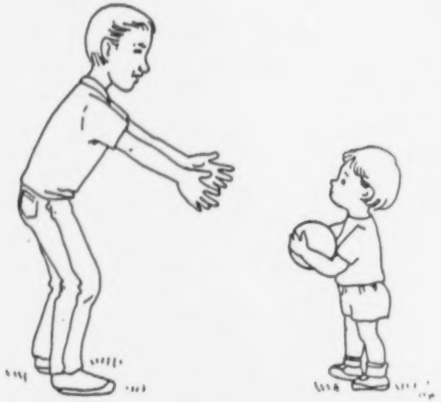
Quiet to Listen

It is important to respond to these early communication signals!

USING INTERACTIVE TURN-TAKING

1. Use activities that involve give and take.

2. Wait for your child to respond.



3. Use a signal to let your child know it is his turn.

4. Imitate your child.

Let's play with the ball now.

5. Change activities if your child isn't interested in what you are doing.

6. Avoid being a turn grabber!

RESOURCE MATERIALS FOR TRAINER

ible 6-1 Nine Characteristics of Infant Temperament Found to Remain Rela-
'ely Stable from Infancy Through the Tenth Year of Life

Temperamental Quality	Rating	2 Months	6 Months	1 Year	2 Years	5 Years	10 Years
ivity Level	High	Moves often in sleep. Wriggles when diaper is changed.	Tries to stand in tub and splashes. Bounces in crib. Crawls after dog.	Walks rapidly. Eats eagerly. Climbs into everything.	Climbs furniture. Explores. Gets in and out of bed while being put to sleep.	Leaves table often during meals. Always runs.	Plays ball and eng in other sports. C sit still long enou do homework.
	Low	Does not move when being dressed or during sleep.	Passive in bath. Plays quietly in crib and falls asleep.	Finishes bottle slowly. Goes to sleep easily. Allows nail-cutting without fussing.	Enjoys quiet play with puzzles. Can listen to records for hours.	Takes a long time to dress. Sits quietly on long automobile rides.	Likes chess and re ing. Eats very slow
thmicity	Regular	Has been on four-hour feeding schedule since birth. Regular bowel movement.	Is asleep at 6:30 every night. Awakes at 7:00 A.M. Food intake is constant.	Naps after lunch each day. Always drinks bottle before bed.	Eats a big lunch each day. Always has a snack before bedtime.	Falls asleep when put to bed. Bowel movement regular.	Eats only at meal Sleeps the same amount of time ea night.
	Irregular	Awakes at a different time each morning. Size of feedings varies.	Length of nap varies; so does food intake.	Will not fall asleep for an hour or more. Moves bowels at a different time each day.	Nap time changes from day to day. Toilet training is difficult because bowel movement is unpredictable.	Food intake varies; so does time of bowel movement.	Food intake varies Falls asleep at a di ent time each nigh
ictibility	Distractible	Will stop crying for food if rocked. Stops fussing if given pacifier when diaper is being changed.	Stops crying when mother sings. Will remain still while clothing is changed if given a toy.	Cries when face is washed unless it is made into a game.	Will stop tantrum if another activity is suggested.	Can be coaxed out of forbidden activity by being led into something else.	Needs absolute sil for homework. Ha hard time choosin shirt in a store bec they all appeal to h
	Not Distractible	Will not stop crying when diaper is changed. Fusses after eating, even if rocked.	Stops crying only after dressing is finished. Cries until given bottle.	Cries when toy is taken away and rejects substitute.	Screams if refused some desired object. Ignores mother's calling.	Seems not to hear if involved in favorite activity. Cries for a long time when hurt.	Can read a book w television set is at volume. Does cho on schedule.
ach rawal	Positive	Smiles and licks washcloth. Has always liked bottle.	Likes new foods. Enjoyed first bath in a large tub. Smiles and gurgles.	Approaches strangers readily. Sleeps well in new surroundings.	Slept well the first time he stayed overnight at grandparents' house.	Entered school building unhesitatingly. Tries new foods.	Went to camp hap Loved to ski the fi time.
	Negative	Rejected cereal the first time. Cries when strangers appear.	Smiles and babbles at strangers. Plays with new toys immediately.	Stiffened when placed on sled. Will not sleep in strange beds.	Avoids strange children in the playground. Whimpers first time at beach. Will not go into water.	Hid behind mother when entering school.	Severely homesick camp during first d. Does not like new activities.
bility	Adaptive	Was passive during first bath; now enjoys bathing. Smiles at nurse.	Used to dislike new foods; now accepts them well.	Was afraid of toy animals at first; now plays with them happily.	Obeys quickly. Stayed contentedly with grandparents for a week.	Hesitated to go to nursery school at first; now goes eagerly. Slept well on camping trip.	Likes camp, althou homesick during fi days. Learns enthus astically.
	Not Adaptive	Still startled by sudden, sharp noise. Resists diapering.	Does not cooperate with dressing. Fusses and cries when left with sitter.	Continues to reject new foods each time they are offered.	Cries and screams each time hair is cut. Disobeys persistently.	Has to be hand-led into classroom each day. Bounces on bed in spite of spankings.	Does not adjust we new school or new teacher; comes hon late for dinner eve when punished.

From "The Origin of Personality," by Alexander Thomas, Stella Chess, and Herbert G. Birch. ight © 1970 by Scientific American, Inc. All rights reserved.

(contin.

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ble 6-1 *(continued)*

Temperamental Quality	Rating	2 Months	6 Months	1 Year	2 Years	5 Years	10 Years
ntion Span Persistence	Long	If soiled, continues to cry until changed. Repeatedly rejects water if he wants milk.	Watches toy mobile over crib intently. "Coos" frequently.	Plays by self in playpen for more than an hour. Listens to singing for long periods.	Works on a puzzle until it is completed. Watches when shown how to do something.	Practiced riding a two-wheeled bicycle for hours until he mastered it. Spent over an hour reading a book.	Reads for two hours before sleeping. Does homework carefully.
	Short	Cries when awakened but stops almost immediately. Objects only mildly if cereal precedes bottle.	Sucks pacifier for only a few minutes and spits it out.	Loses interest in a toy after a few minutes. Gives up easily if she falls while attempting to walk.	Gives up easily if a toy is hard to use. Asks for help immediately if undressing becomes difficult.	Still cannot tie his shoes because he gives up when he is not successful. Fidgets when parents read to him.	Gets up frequently from homework for a snack. Never finishes a book.
sity ction	Intense	Cries when diapers are wet. Rejects food vigorously when satisfied.	Cries loudly at the sound of thunder. Makes sucking movements when vitamins are administered.	Laughs hard when father plays roughly. Screamed and kicked when temperature was taken.	Yells if he feels excitement or delight. Cries loudly if a toy is taken away.	Rushes to greet father. Gets hiccups from laughing hard.	Tears up an entire page of homework if one mistake is made. Slams door of room when teased by younger brother.
	Mild	Does not cry when diapers are wet. Whimpers instead of crying when hungry.	Does not kick often in tub. Does not smile. ~~Screams and kicks~~ when temperature is taken.	Does not fuss much when clothing is pulled on over head.	When another child hit her, she looked surprised, did not hit back.	Drops eyes and remains silent when given a firm parental "No." Does not laugh much.	When a mistake is made in a model airplane, corrects it quietly. Does not comment when reprimanded.
hold of nsiveness	Low	Stops sucking on bottle when approached.	Refuses fruit he likes when vitamins are added. Hides head from bright light.	Spits out food he does not like. Giggles when tickled.	Runs to door when father comes home. Must always be tucked tightly into bed.	Always notices when mother puts new dress on for first time. Refuses milk if it is not ice-cold.	Rejects fatty foods. Adjusts shower until water is exactly the right temperature.
	High	Is not startled by loud noises. Takes bottle and breast equally well.	Eats everything. Does not object to diapers being wet or soiled.	Eats food he likes even if mixed with disliked food. Can be left easily with strangers.	Can be left with anyone. Falls asleep easily on either back or stomach.	Does not hear loud, sudden noises when reading. Does not object to injections.	Never complains when sick. Eats all foods.
d	Positive	Smacks lips when first tasting new food. Smiles at parents.	Plays and splashes in bath. Smiles at everyone.	Likes bottle; reaches for it and smiles. Laughs loudly when playing peekaboo.	Plays with sister; laughs and giggles. Smiles when he succeeds in putting shoes on.	Laughs loudly while watching television cartoons. Smiles at everyone.	Enjoys new accomplishments. Laughs when reading a funny passage aloud.
	Negative	Fusses after nursing. Cries when carriage is rocked.	Cries when taken from tub. Cries when given food she does not like.	Cries when given injections. Cries when left alone.	Cries and squirms when given haircut. Cries when mother leaves.	Objects to putting boots on. Cries when frustrated.	Cries when he cannot solve a homework problem. Very "weepy" if he does not get enough sleep.

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[illegible]

care, health and development, 1990, 16, 55–61

Early language development and severe visual impairment

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Accepted for publication 25 May 1989

Summary Some blind children show an early facility with expressive language in advance of their true level of comprehension; children who have severely impaired vision, but use visually-directed reaching, do not. Inspection of developmental assessments of 40 blind and very severely visually impaired children with no other disability, seen at the Wolfson Centre, London, confirmed these patterns. However, a considerable number of blind children showed a lag in expressive speech relative to comprehension, which might mean first words appearing as late as 2 years of age. Later assessments of this group of children showed mixed outcomes. Further prospective research is indicated as a basis for counselling parents.

It has been established by a number of surveys that blind children tend to develop first words later than sighted children do (e.g. Norris *et al.* 1957, Reynell 1978). The content of blind children's early spoken words tends to emphasize people's names and be related to their own body movements. Social phrases may be imitated as a whole and then used in more or less appropriate contexts (Urwin 1983).

This facility with some structures of spoken language may 'outstrip' the attained level of verbal comprehension, if reference is made to the usual relationship between comprehension and expression in sighted children. For example, sighted children may be expected to say their first meaningful word at around the same time as they can make an appropriate response to a simple request (not entirely cued by context) such as 'Show me your tummy' or 'Give me the cup'. A blind child may produce first words 9 months or so before co-operation with requests is well established (Reynell 1979). (Relevant information is presented in Figure 1.)

Raw score	Verbal Comprehension			Expressive Language Structure		
		Age equivalent (months)		Age equivalent (months)		
		Sighted	Blind	Sighted	Blind	
6	Recognition of familiar sounds	7	10-12	8-9*	8-10	Repetitive double-syllable babble
7	Recognition of familiar words or phrases	8	12-14	10-11	11-14	One definite word
8	Appropriate response to familiar phrase or words	9-10	14-19	12-13	15-18	Expressive jargon
9	Appropriate response to request (e.g. Where is your nose ?)	10-12*	19-22	14-15	19-22	Two-three meaningful words

FIGURE 1. Extract from age equivalent tables for Reynell-Zinkin Developmental Scales for young visually handicapped children.* Sample development levels represented by an expressive lag of 2–3 months (see text).

For severely visually impaired children who have enough vision to show visually-directed reaching for objects on a table, expressive speech has not been found to show this early pattern. Thus, at the stage of jargon and two to four 'situational' words, blind children on average are ahead of the partially-sighted group. When words begin to be true object labels (just past 2 years of age), the partially-sighted begin to show a developmental advantage (Reynell 1978).

However, inspection of average age levels is not indicative for individual patterns of development. In the Developmental Vision Clinic at The Wolfson Centre, London, clinical experience suggested that some blind children were not early talkers and imitators of adult language. Their comprehension would appear to be developing normally, allowing for effects of visual impairment, but they might start to speak only at about 2 years of age. This pattern tended to be worrying for parents alert for signs of intellectual disability in addition to their child's blindness. Late walking and talking are constantly commented on and not understood by relatives and friends.

Therefore, a survey was undertaken of the case records of severely visually impaired children attending the Wolfson Centre who had no other apparent disability, in order to examine further patterns of language development in the second year of life, and later outcome.

SUBJECTS

Eighty-five children were classified on first assessment by a paediatrician as having 'no other disability' from 350 seen in the Developmental Vision Clinic (DVC) between 1973 and 1986. The children are referred from all parts of Greater London and Essex, and additionally many come from other parts of England and Wales.

Of the 85 case records screened, 60 included completed records of assessment between 13 and 24 months of age of children's sensorimotor understanding, verbal comprehension and expressive language structure using the Reynell-Zinkin Developmental Scales for Young Visually Handicapped Children. In each case, the age equivalent of the score for sensorimotor understanding was close to the child's chronological age. The remaining children were either first seen over the age of 2 years, or had incomplete assessment information. (It should be noted that standardized assessment of severely visually impaired children at this age is particularly difficult in that children are often uncooperative with adult requests.)

Of the 60 case records available, 20 of the children had been assessed as totally blind or having minimal light perception. Twenty more were very severely visually impaired (VSVI); visual perception in this group ranged from awareness of a 5-inch dangling object at 10 cm to awareness of a Stycar white ball of 2½-inch diameter at 1 metre distance. (The vision of the remaining 20 children was better, though still severely visually impaired. They will not be discussed further in this paper.) The diagnoses in the blind children included Leber's amaurosis, anophthalmos, microphthalmos, Norrie's disease or other retinal dysplasia, and retrolental fibroplasia. The diagnoses in the VSVI children included optic atrophy, congenital cataracts, albinism, Leber's amaurosis and microphthalmos.

PROCEDURE

The raw scores for assessment of verbal comprehension and expressive nguage structure were related to the age equivalents for sighted ildren (Reynell 1979). By taking the mid-point of the age band presenting any raw score point, the discrepancy between compre- nsion and expression was calculated for each child for assessments rried out between 13 and 24 months. (NB The 'blind' and 'partially- ghted' age equivalents were not used, as the former already reflect e relative advance in some children's spoken language structure at is age. In addition, the inclusion by Reynell of adjusted age levels rived from assessments of children with learning difficulties might fect comparison with the present sample in unknown ways.)

ESULTS

r the blind children, the discrepancy ranged from plus 13 months e. expressive structure ahead in relation to expectations derived m sighted children) to minus 3 months. For the VSVI children, the screpancy ranged from plus 3 to minus 7 months (see Figure 2). Thus, as suggested by other studies, several blind children had pressive performance which seemed greater than their 'real' level of derstanding. For example, the child with the greatest discrepancy ·13 months) was beginning to understand requests to select an object m a choice of three presented, while already regularly using well- rmed sentences of three or more words. Children with some vision re much more likely to have expressive levels compatible with mprehension, or even lagging behind.

Seven of the blind children showed a lag of 2–3 months in expression lative to comprehension. Although such a lag would not appear of gnificance in a sighted child, it might appear to represent a major lay in a blind child. That is, a blind child would on average be aged –22 months before comprehension is at the stage of making an propriate response to an instruction out of context. At that stage, an pressive lag of 2–3 months (sighted equivalent) would represent pressive speech limited to double-syllable babble with a first real ord yet to appear (see Figure 1, starred entries).

Further information on language comprehension and expression as available from later assessments for 16 of the 20 blind children (in except one case between 25 and 36 months) (see Figure 3). For four the seven children whose expressive structure had appeared to lag hind comprehension, accelerated development was noted (e.g. from

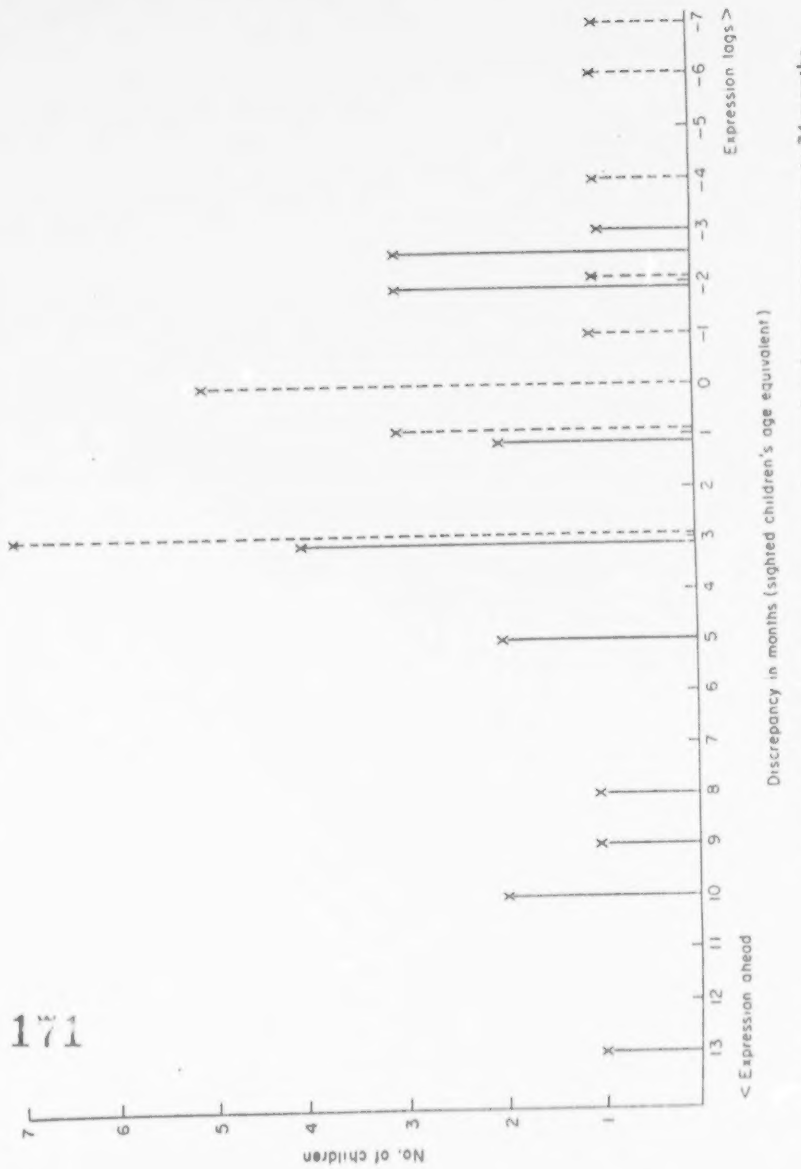

FIGURE 2. Discrepancy between expressive language structure and comprehension on assessment up to 24 months. ——— = blind; -------- = very severely visually impaired.

	At assessment between 13 and 24 months		
At assessment after 2 years	Expression ahead (+13 to +5 months)	Expression = comprehension	Expession lags (−2 to −7 months)
Expression ahead	3	1	2
Expression = comprehension	2	3	2
Severe delay emerges			3

IGURE 3. Later language profile for 16 blind children (R-Z norms).

xpressive jargon to sentences of three or more words in only 7 ionths). However, in three other children a picture emerged of eneral developmental delay (2) or specific language disorder (1). hese children were not distinguishable from the others by aetilogy, social circumstances, or other early signs from case record iformation.

Fourteen of the 20 VSVI children were seen for later assessments nitial assessment discrepancy range +3 months to −4 months). All xcept one showed good developmental progress, seven with exressive level apparently in advance of age equivalents for comprehenon. The one child seemed to have a specific expressive delay until atching up' at 3 years 6 months.

ISCUSSION

he language assessment data obtained from case records of 40 hildren with severe visual impairment and no other apparent isability have confirmed the picture described by others. For some lind children, early expressive language structure is in advance of omprehension, in comparison with expectations derived from sighted hildren, and this pattern is not seen in children with a little vision.

However, an equal number of blind children were found to have ome expressive lag at first. Some of these children were noted to be stening intently to their surroundings, and often to remain silent. he outcome on later assessments for these children was mixed.

In order to begin to understand children's varying early patterns, and even to try to predict outcome in counselling parents, much more detailed research is required. For example, it will be important to look prospectively at the context for development of a child's first words. This might include how parents respond to different kinds of cues given by children (cf. Rowland 1984) and the kinds of instructions and descriptions given to children by parents (cf. Kekelis & Andersen 1984). Such analysis would need also to consider how children are enabled to gain active control over their own world (Urwin 1983). The possible significance of early neurological signs would also need to be considered. The author has received a pilot study grant from the Mary Kitzinger Trust in order to study children's variations in emergent expressive language, the content of first words, and the communicative context of play and interaction with parents in the second year of life.

ACKNOWLEDGEMENTS

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PROJECT VIISA

Instructor's Manual for Course #2

Working with Preschoolers with Blindness and Vision Impairment in Center-Based Settings

SKI-HI Institute
Utah State University
Logan, Utah

APPENDIX E

Home Study Manuals

Course #1 Table of Contents

Sample Home Study Unit from Course #1

Course #2 Table of Contents and General Information

PROJECT VIISA
(Vision Impaired In-Service in America)

A Model In-service Training Program for Early
Intervention/Early Childhood Professionals Serving
Infants, Toddlers, and Preschoolers Who are Blind and
Visually Impaired

Homestudy Manual for Course #1

Early Intervention for Infants and Toddlers with Blindness
and Visual Impairment and Their Families

Instructor/Trainers :
Credit :
Course # :

Text: *Resources for Family Centered Intervention for Infants, Toddlers, and Preschoolers Who Are Visually Impaired.* SKI-HI Institute, 1992.

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HOME STUDY UNITS (Readings and Assignments: face pages are colored sheets)

#1 Early Intervention Which Involves the Family

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#2 Vision
(Medical aspects of vision loss, visual development, assessing functional use of vision and strategies to encourage use of functional vision)
#3 Developing Social-Emotional Skills: Attachment, Communication and Social Behaviors
#4 Childcare Routines
#5 Motor, Orientation and Mobility for the Infant and Toddler
#6 Use of Other Senses to Compensate for Vision Loss (Hearing and Tactile)
#7 Interaction With Objects: Play, Cognition, Concept Development

ADDITIONAL INFORMATION AND INSTRUCTIONS

The Yellow Home Study Cover Sheets

GENERAL INFORMATION

Introduction

The purpose of this course is for participants to gain and develop skills in understanding the unique needs of infants and toddlers who are visually impaired and their families. Course content will include working with families; observation, assessment and developing the Individualized Family Service Plan (IFSP); service delivery options and support services; intervention techniques, curricula and resource materials; developing the use of the senses; special needs of infants and toddlers with vision loss and additional disabilities or medical needs; and supporting transitions.

Throughout the course, the term "children with visual impairment" will be used to refer to children who are blind as well as those with some vision. It is recognized that there can be a wide range of functioning levels within this population and that some of the needs and methodology for children who are blind can be quite different from that of children with low vision or multiple disabilities. Emphasis is also placed on working with families and caregivers rather than just parents alone.

Philosophy

Young children who are visually impaired have unique educational needs based on their individual developmental differences. These include the following:

1. Predictability in their daily routines.
2. Motivation to move out and explore the environment as well as orientation to familiar and unfamiliar environments.
3. Concrete, hands-on learning experiences which utilize materials that are meaningful to the child, realistic, and provide multisensory information.
4. Assistance in learning to use all available sensory information about their environment (i.e., sight, sound, smell, touch, taste).
5. Adequate amount of time to learn about concepts, to accomplish tasks, and for repeated exposure to certain experiences.
6. Help in integrating concepts and in generalization of learned experiences.
7. Developing a positive self-concept and sense of independence and mastery.
8. Learning appropriate social skills and customs.
9. Experience based language activities.
10. Education in compensatory skill areas such as orientation and mobility, Braille, functional use of vision, and listening.

These children and their families can benefit most from early intervention provided by professionals who have some training and experience with this population. These professionals must work in collaboration with the family and other appropriate team members (e.g., medical, vision specialist, orientation and mobility, occupational/physical/speech therapy, early intervention or childhood specialist) in planning for and implementing a program that best meets the needs of the child as well as the concerns and priorities of the family. Service providers must also be sensitive to multicultural issues when working with families of differing cultural backgrounds. A variety of service options must be made available to the family. And finally, information, planning, communication and support must be provided during times of transition from one type of program to the next.

Course Objectives

A. Students will gain knowledge of the following as it relates to the needs of infants and toddlers with visual impairment and their families.

1. The effects of visual impairment on child development, learning and behavior.
2. Other disabling conditions which may accompany vision loss.
3. Special needs of premature infants with vision loss.
4. Medical aspects, types and functional implications of specific eye conditions.
5. Visual development.
6. Observation and assessment of functional use of vision and strategies for encouraging functional use of vision.
7. How to encourage use of other senses to compensate for loss of vision (i.e., hearing and tactile).
8. Strategies for enhancing attachment and communication between parent and child.
9. Experiential learning verses manipulative learning.
10. Cognition and problem solving skills.
11. Strategies for developing appropriate social skills.
12. Strategies for developing motor skills.
13. Strategies to use in daily care and for building independence in self-care.
14. Specialized equipment and materials.
15. Assessment methods and tools for use with infants and toddlers who are visually impaired and their families.
16. Resources and services.
17. Appropriate service delivery options for this population.
18. Interaction among familial, cultural, social and physical environments which may influence the young child in achieving optimal growth and development.
19. Transitioning issues.

B. In serving this population, the student will demonstrate the ability to:

1. Work effectively with families and adapt for cultural differences.
2. Develop and implement programs geared to the unique needs and strengths of the child as well as to the family's concerns and priorities.
3. Observe activities and interpret experiences from the infant's and toddler's perspective.
4. Assess the child's level of development, set goals and design learning activities appropriate to the child's level of development in collaboration with the family.

5. Integrate and interpret medical as well as assessment information, explain results to other professionals and parents and generate recommendations for educational programming.
6. Develop an appropriate IFSP with the family and other service providers.
7. Implement, evaluate, and adapt learning experiences which address the needs of infants and toddlers with visual impairment.
8. Utilize support people and resources as appropriate (i.e., vision, orientation and mobility, occupational/physical/speech therapy, medical, social worker or counselor, specific agencies) and participate as a team member.
9. Interpret the child's behavior to others as needed.
10. Encourage the use of other senses (i.e., touch, hearing, and smell) to compensate for the visual loss.
11. Assess functional vision and facilitate further development of functional visual skills.
12. Design and implement curriculum and teaching strategies for the development and improvement of skills in gross and fine motor, communication, self-care, cognition and concept development, play, social and emotional.
13. Assist in transition from home to center-based preschool setting.

Meet Your Instructor/Trainers

Note: In this space type a brief description of the training and background of each instructor or trainer that will help to teach the class. Provide phone numbers, address where homestudy assignments are mailed, and best times to reach them. Obtain this information directly from the instructor or trainers.

HOME STUDY UNIT #2

VISION

HOME STUDY UNIT #2

Vision

This unit has two parts (I and II). You are required to do all assigned readings and to select only one assignment from one of the parts to be sent to the instructor. In other words, you have just one assignment to do for this unit.

Part I: Understanding the medical aspects, types and functional implications of conditions causing visual impairment.

Introduction:

This information covers the anatomy and function of the visual system and the impact on vision if an eye condition or cortical visual impairment (CVI) is diagnosed. Information about eye specialists, exams and reports is also provided so that teachers and parents know what to expect during a routine eye exam.

Objectives:

1. Participants will state how the visual system works and identify typical visual behaviors of infants/toddlers during the first two years of life.
2. Participants will identify the most common eye conditions and their functional implications affecting infants and toddlers.
3. Participants will read a doctor's eye report and identify the eye disorder.
4. Participants will distinguish the differences between ocular eye disorders and CVI.

Required Readings:

1. *Resource Manual for VI*
   a. Unit 4, Learning through the Senses, Introduction
   b. Chapter 1, Vision, Section 1, Vision Information, topics 1-4
2. "Normal Visual Development" - *Parent Articles for Intervention,* (1990), Communication Skill Builders, Tucson, AZ.
3. Pages on Cortical Visual Impairment from Texas School for the Blind "Low Vision" Manual, (1991), pp. 16, 17, 131.
4. Appleby Summary of Key Points in January article on CVI (1987).

Recommended Resources:

1. Creger, Pam, J. et al (1989), "Developmental intervention for preterm and high risk infants", Module 3 on Vision in *The Hospitalized Infant*, pp. 46-63, Communication Therapy Skill Builders.

2. Goldberg, Stephen, MD. (1982). *Ophthalmology made ridiculously simple.* Miami, FL: Med Master, Inc. 1982.

3. Hanson, M (1988) *Beyond tracking: Enhancing vision development from birth to one year.* Vision Unlimited, P.O. Box 1591, Bridgeview, Illinois 60455

4. Jan, J.E. and Groenvold, M. "Visual behaviors and adaptations associated with cortical and ocular impairment in children." *Journal of Visual Impairment and Blindness*, 87, 101-105.

5. Step-by-Step. Chart, Visual Developmental Sequence from *It's More Than a Flashlight*, birth - 2 years.

How to Proceed:

As you review the assigned readings, keep these focusing questions in mind:

1. How can the function of the visual system be affected by a visual impairment?

2. Given your knowledge of normal visual development, how can caregivers go beyond the diagnosis of the eye condition to promote an infant's learning?

3. How can caregivers effectively communicate with the eye care specialist during a routine eye exam?

Assignments:

Choose one of the following options (e.g., A-1, B-2) and submit a one to two page paper with descriptions of the situation and suggestions.

A: Reaction to Readings

1. Discuss how the visual system works and provide an overview of normal visual behaviors/skills that appear during the first two years of life. Pick one common eye disorder and identify how the visual system is affected and the possible functional implications.

2. Describe cortical visual impairment and discuss at least 10 functional implications of this condition.

B: Application Through Practicum

1. Discuss a child's eye condition with the parent during a home visit or meeting with the caregiver.

   - Identify an infant or toddler who is visually impaired (if possible, a child that you presently work with). During a home visit or meeting with the caregiver, discuss the child's eye condition.

   - Using pictures provided in the manual, show the caregiver where the visual system has been affected.

   - Brainstorm the functional implications of the child's eye condition with the caregiver. (e.g., How will lighting affect the child's use of vision? Are particular colors more stimulating than others? Would certain placements of material allow the child to see visual stimuli more easily?)

2. Accompany a caregiver and infant to an appointment with an eye care specialist.

   - Take page 896, Vision (Section 1). Questions to ask the Eye Doctor with you.

   - Summarize your observations of the interactions between doctor and caregiver, citing specific recommendations made by the doctor.

3. Use Directions for Making a Visual Simulator (p. 908 of manual) with a caregiver at a home visit or meeting.

   - The caregiver can perform routine activities while wearing the simulator.

   - Record the caregiver's reactions/feelings and/or other comments and report your observations and findings.

HOME STUDY UNIT #2

Part II: Vision Utilization for Infants and Toddlers

Introduction:

This information discusses the importance of facilitating an infant's use of vision, even if a visual impairment has been diagnosed. Though two infants/toddlers may have the same medically diagnosed visual impairment, each infant/toddler may use vision differently. For example, two children with aphakia (lenses removed because of cataracts) may have tested visual acuities of 20/200. However, through observation, we see one child uses vision to pick up small items from the floor and accurately reaches for finger food. The other child may use a tactual approach to accomplish the same tasks. This is an example of a functional difference in the use of vision. At the completion of this home study section, you will know important areas tested in a functional vision assessment procedure.

Objectives:

1. Participants will identify the important component areas in a functional vision assessment procedure.

2. Participants will develop strategies for encouraging use of vision given the results of a child's functional vision assessment.

Required Readings:

1. *Resource Manual for VI*

    a. Unit 4, Chapter 1, Section 2, Vision Utilization, Topics 1-11.

2. "Testing Your Child's Vision". *Parent Articles for Early Intervention* (1990), Communication Skill Builders, Tucson, AZ.

3. Goetz, L., Guess, P., Stremel-Campbell (1987), "Functional Vision Programming", *Innovative program design for individuals with dual sensory impairments*. Baltimore, Paul H. Brooks.

Recommended Resources:

1. Harrell, L. & Akeson, N. (1987). "Preschool Vision Stimulation", *It's More Than a Flashlight*, pp. 11-14.

2. Hanson, M. (1988). *Beyond tracking: enhancing vision from birth to one year of age.* Vision Unlimited, PO Box 1591, Bridgeview, IL, 60455.

3. Smith, A.J. & Cote, K.S. (1982). *Look At Me: A resource manual for the development of residual vision in multiply impaired children.* Philadelphia: Pennsylvania College of Optometry.

4. Preston, Karen, O.D. (1987). Infant Vision Testing with the Teller Acuity Card Procedure. (brochure)- from Howard L. Freedman, MDPS, 17130 Avondale Way, N.E., Redmond, WA 98052, 206-885-6600.

5. Hall, A., Orel - Baxter, D.; Haegerstrom - Portnoy, G. (1991). Visual assessment techniques for multiply handicapped persons. Journal of Visual Impairment and Blindness, 85, pp. 23028.

How to Proceed:

As you review the assigned readings, keep these focusing questions in mind:

1. How can caregivers modify their interactions to facilitate their child's use of vision?
2. How can caregivers assess the environment to enhance their child's use of vision?
3. How can caregivers use their knowledge of the sequence of development in visual recognition and discrimination to enhance their child's use of vision?

Assignments:

Choose one of the following options (i.e., A-1, B-1) and submit a one to two page paper with descriptions of the situations and suggestions.

A: Reaction to Readings

1. Identify an infant or toddler who is visually impaired.

   - Describe the infant's/toddler's use of vision using Topics 1-11 of Section 2 (when applicable) in the manual (pp. 932-1043).

   - Develop a plan for enhancing the child's use of vision using at least two of the topic areas.

   - Write up and submit a 1-2 page report.

B: Application Through Practicum

1. Discuss one of the following topics during a home visit with a caregiver, as appropriate for the child.

   Topics:
   1: Observation and Identification of Visual Skills (p. 932).
   2: Assessing and Modifying the Environment to Enhance Visual Functioning (p.951).
   3: Visual Stimuli (p. 966).
   4: Looking Behaviors (p. 978).
   5: Visual Field (p. 994).

   - Discuss the topic and use one of the sample activities and challenges. Write up a brief two page report which includes:

   1. your reason for selecting this topic
   2. an evaluation of your discussion
   3. caregiver's responses/participation
   4. results of the sample activity and challenge
   5. your reactions/evaluation of the experience

2. Discuss the ways in which the caregiver has observed his/her child using vision during a home visit or meeting with a caregiver.

   - Ask for examples of situations and behaviors. Share your observations.

   - If a caregiver identifies a problem, develop 2 suggestions that might help the caregiver to enhance the child's use of vision.

PROJECT VIISA
(Vision Impaired In-Service in America)

A Model In-Service Training Program for Early
Intervention/Early Childhood Professionals Serving
Infants, Toddlers, and Preschoolers Who are Blind and
Visually Impaired

Homestudy Manual for Course #2

Early Intervention for Infants and Toddlers with Blindness
and Visual Impairment and Their Families

Instructor/ Trainers :
Credit :
Course # :

Text: *Resources for Family Centered Intervention for Infants, Toddlers, and Preschoolers Who Are Visually Impaired.* SKI-HI Institute, 1992.

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HOME STUDY UNITS (Readings and Assignments: face pages are colored sheets)

#1 Introduction to Working with Preschoolers with Vision Loss in Center-Based Settings
#2 Interacting with People
#3 Use of Functional Vision Reading Readiness

#4 Braille Readiness and Listening Skills
#5 Self-Care and Independence
#6 Orientation and Mobility
#7 Cognition and Concept Development
#8 Assessment and the IEP

ADDITIONAL MATERIAL

VIISA Brochure
Special Requests
The Yellow Home Study Cover Sheets

GENERAL INFORMATION

Introduction

The purpose of this course is to familiarize the participants with the unique needs of preschoolers who are blind or visually impaired in the center-based setting. The focus will be on working with these children in the preschool setting as well as in collaboration with the family and other members of the service delivery team. Transitioning from the preschool to the elementary school setting will also be addressed. The students will gain knowledge and skills in observation, assessment, the IEP process, intervention techniques, use of appropriate methods, curricula and materials in teaching skills in all developmental domains, developing the use of all senses, meeting the child's needs in the group setting, socialization, school readiness and compensatory skill training (i.e., braille readiness, orientation and mobility).

The Needs and Rights of Children Who Are Blind and Visually Impaired

The following four statements were prepared by the participants of the XIVth. International Seminar on the Preschool Blind, June, 1990.

1. The impact of vision loss on the child and family must be understood and addressed.

   Lack of vision limits much of a child's ability to:

   - Know where he is and how to move from place to place.
   - Imitate and interact socially.
   - Understand what causes things to happen.

   Children learn to play with others by watching, moving close to the action, and then joining in the game. A child who cannot see others playing, who doesn't know how to move closer to them, and who has no way to find out how the game is played, often becomes isolated. As a result, this child may be perceived as withdrawn or developmentally delayed. Special training is required to understand the role that vision plays in development and to master the techniques for teaching the skills that deal with the effects of blindness and visual impairment.

2. Children who are blind or visually impaired and their families require early intervention services.

   Childhood blindness or visual impairment has an impact on the entire family system. Services should begin as soon as a vision problem is diagnosed in order to encourage a child's development and to prevent or minimize secondary conditions such as withdrawal, stereotypic behaviors (for example, eye poking, rocking), school failure, and family stress.

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3. Children who are blind or visually impaired and their families have a right to qualified instructors and specialists.

The people specifically trained to provide educational services to a child who is blind or visually impaired are:

- Teachers of the visually impaired.
- Orientation and mobility instructors.

4. Children who are blind or visually impaired and their families have a right to appropriate special services and instruction.

The following services must be integrated into a program that promotes independence for each child.

- Cognitive development opportunities (learning basic concepts, problem solving skills).
- Communication skills instruction (listening, turn-taking, personal expression, braille readiness).
- Gross and fine motor training (developing physical control and stamina).
- Low vision training (learning to use vision).
- Orientation and mobility instruction (learning to move independently in the environment).
- Parent education and family support (developing understanding skills, and the ability to access personal and community resources).
- Recreation opportunities (enhancing creativity and enjoyment).
- Sensory training (learning to use the senses).
- Social skills instruction (learning skills for daily living and relationships).

These children and their families can benefit most from early intervention provided by professionals who have some training and experience with this population. These professional must work in collaboration with the family and other appropriate team members (i.e., medical, vision specialist, orientation and mobility, occupational/physical/speech therapy, early intervention or childhood specialist) in planning for and implementing a program that best meets the needs of the child as well as the concerns and priorities of the family. Service providers must also be sensitive to multicultural issues when working with families of differing cultural backgrounds. A variety of service options must be made available to the family. And finally, information, planning, communication and support must be provided during times of transition from one type of program to the next.

What You Should Know About Blindness and Visual Impairment in Children

The following statements were prepared by the participants of the XIVth. International Seminar on Preschool Blind, June, 1990.

- The development of the child who is blind or visually impaired is highly individual, as it is with all children.
- Vision is the primary learning modality and source of information for most children.
- No other sense can stimulate curiosity, integrate information or invite exploration in the same way, or as efficiently and fully, as vision does.
- The child who is blind or visually impaired has many needs in common with all children. Among these are the needs for a sense of worth and accomplishment.
- Children who are blind cannot learn to do things by visual imitation. Children who are blind or visually impaired often require more "hands-on" experience, time, practice, and guidance in order to learn skills.
- More efficient hearing and a finer sense of touch, smell or taste do not develop automatically in a young child who is blind or visually impaired.
- Specialized training in the effective and efficient use of vision, hearing, touch, smell, and taste can bring about increased skill in their use.
- Because most parents have not had the opportunity to know a child who is blind or visually impaired, they can often benefit from the assistance provided by trained professionals and other parents who have had such an experience, and adults who are blind or visually impaired.
- Many children who are blind or visually impaired have other disabilities.
- The relationship between blindness and other disabilities is complex. Assessment and programming become complicated and may require the services of a variety of disciplines.
- Instruction specific to their disability is essential for young children who are blind or visually impaired in order to meet their unique developmental needs.

Course Objectives

A. Students will gain knowledge of the following as it relates to preschoolers with visual impairment and their families.

1. The effects of visual impairment on the development, learning and behavior of the preschooler.
2. The needs of preschoolers with vision loss in the group setting.
3. Curricula, specialized equipment and materials.
4. Assessment methods and tools for use with this population.
5. Assessment of functional vision and methods to encourage further development of functional visual skills.
6. The IEP process and working as a team member.
7. Resources and services for preschoolers.
8. Models of service delivery for preschoolers.
9. Appropriate classroom management skills including use of space, time, instructional methods, materials, curricula, equipment and computer technology.
10. How to adapt each area of the curriculum for early childhood to the unique needs of this population (i.e., art, music play, literature, adaptive behavior, science, movement, social, concepts, language).
11. Methods of instruction for preschool children including physical and sensory stimulation, activity based, experiential, and parent mediated.
12. How to help parents remain involved with their child's program.
13. How to encourage independence in the preschooler with vision loss.
14. How to facilitate appropriate social behavior and peer interaction.
15. Compensatory skill areas (i.e., orientation and mobility, braille, listening).
16. Selection and transition to the elementary school setting.
17. Special needs of preschoolers with additional disabilities.

B. In working with this population, the student will demonstrate the ability to:

1. Work effectively with preschoolers who are visually impaired.
2. Develop and implement programs geared to the unique needs of these children in the center-based setting.
3. Work effectively with other team members.
4. Observe activities and interpret experiences from the preschooler's perspective.
5. Assess, set goals and design learning activities appropriate to the child's level, needs, interests and strengths in collaboration with the family and other team members.
6. Integrate and interpret medical as well as assessment information, explain results to other professionals and parents and generate recommendations for educational programming.
7. Develop an appropriate IEP in collaboration with the family and other service providers.
8. Implement, evaluate, and adapt learning experiences which address the needs of preschoolers with visual loss.

9. Utilize support people and resources as appropriate (i.e., vision, speech, orientation and mobility, occupational/physical therapy, medical, social worker or counselor, agencies) and participate on a transdisciplinary team.
10. Encourage use of other senses (i.e., touch, hearing and smell) to compensate for the visual loss.
11. Assess functional vision and facilitate further development of functional visual skills.
12. Design and implement curriculum and teaching strategies for the development and improvement of skills in orientation and mobility, motor, language, self-care, cognition and concept development, play, fine motor, social and emotional.
13. Work cooperatively with the parents to assist in developing and using appropriate behavior management strategies to deal with specific problems of the preschooler.
14. Assist in transition from preschool to elementary school.
15. Build on the child's as well as the family's areas of strength.
16. Facilitate appropriate social behavior in various settings.
17. Encourage independent functioning of the child as appropriate.
18. Assist parents in becoming actively involved in the planning, implementation and evaluation of their child's educational program.
19. Provide support and information to the family as needed.

Meet Your Instructor

Note: In this space type a brief description of the training and background of each instructor or trainer that will help to teach the class. Provide phone numbers, address where homestudy assignments are mailed and best times to reach them. Obtain this information directly from the instructor or trainers.

Course Requirements and Schedule

Note: (What is described in this home study manual is VIISA format #1.)

Course Format

This course consists of two, 2 day onsite classes (14 hours), one at the beginning of the course and the other near the end; 8 home study units; and a practicum.

Registration and Time for Completion

Registration will be completed by mail prior to the first onsite class. There is a $__ fee payable by check to ________. __________ credit is available for satisfactorily completing the coursework.)

Withdrawals, Refunds, Incompletes

Withdrawals are accepted, if necessary, but refunds of registration fees cannot be made once the course has started. Incompletes are discouraged. If you do not complete the first course, you cannot take the second VIISA course. Most University policies provide a year to finish. If at the end of one year course work has not been completed, the "I" on the transcript converts to an "F."

Absences

If you have to miss part or all of an onsite class, you need to let the instructor/trainers know immediately by phone explaining the reason or else 5 points will automatically be taken off your grade. You may earn up to 50% of the points for that class back by writing a letter to the instructor/trainers outlining a proposal for how you could make that class time up. This may include such things as:

a. Watching the videos shown in the class and writing a reaction paper to them. They would have to send you copies of those videos.

b. Doing some additional practicum assignments related to the topics covered in the class you missed.

You are responsible for resolving this problem. The trainer must approve your proposal and it can be finalized over the phone or by mail.

Securing Textbooks and Materials

All necessary course materials will be shipped directly to you following receipt of registration form and required fees. Participants will receive the Project VIISA Home Study Assignment Manual. You need to purchase the following text:
(1) *Resources for Family Centered Intervention for Infants, Toddlers and Preschoolers Who Are Visually Impaired,* HOPE, Inc., 809 N. 800 E., Logan, UT, 84321, (801) 752-9533 at $85 plus shipping and handling.

Methods of Study

1. To orient yourself to the course, read your Project VIISA Home Study Assignment Manual for course objectives, course information, assignment procedures, and deadlines. Become familiar with the course requirements, textbook, materials and readings. Note that Home Study Unit #1 is to be completed and an assignment is to be mailed to your instructor/trainer before the first onsite class. It will be read, feedback given and returned to you at the first class.

2. Take notes in class and participate in discussions. Proceed with the completion of the individual assignments. Complete the necessary readings, taking note of information needed for the assignments.

The First Onsite Class

The first two-day onsite class with the instructor/trainers will take place at a central location in the state. The class will consist of lectures supplemented with a variety of media; observation and application with case studies on video; work in small group sessions; exposure to resource (i.e., materials, curricula, agencies, and personnel); class discussion; and going over the assignments and plan for the course itself. The topics for the first onsite class are as follows:

- Course Overview, Requirements, How to Proceed with the Home Studies and the Practicum, Getting to Know Each Other
- Introduction to Working with Preschoolers with Vision loss in the Center-Based Setting
- Interacting with People (Language, Social Skills, and Play with Peers)
- Reading Readiness Experiences
- Determining Reading Medium
- Current Research and Practices
- Activities of Daily Living
- Keeping the Family Involved

In the two months following the first onsite session, participants should complete the next four homestudy units. The assignments for each unit should be mailed to the instructor/trainer for feedback and returned for inclusion in your portfolio.

The Midterm Regional Session

(This is where it would briefly be describe it if one is being offered.)

The Final Onsite Class

Near the end of the course, a final two day onsite class with the instructor/trainers will take place. It will be very much like the first one, but covering new content. You will evaluate the course. Information on the second course along with plans for when and where it will begin will also be discussed. The topics for the second onsite class are as follows:

- Questions about and discussion of material covered thus far; Sharing
- Cognition and Concept Development
- Orientation & Mobility
- Preschoolers with Additional Disabilities
- Child Assessment and the IEP
- Choosing the Appropriate Elementary Placement and Transition Issues
- Course Evaluation and Wrap-Up

Class Schedule

Homestudy Unit 1	
First Onsite Class	(include dates, time, location)
Homestudy Units 2,3,4,5	
(Midterm Session)	(include dates, time, location if being offered)
Final Onsite Class	(include dates, time, location)
Homestudy Units 6, 7, and 8	

Completing Homestudy Assignments for the Portfolio

You are required to complete eight homestudy assignments for this course. It would be wise for you to first look over all of the units and tentatively choose which eight assignments in the eight units you might do. Four of those must be done through the practicum. This way you can plan out how to incorporate those four assignments into your practicum experiences (see details about the practicum later in this section). You might want to choose practicum assignments that can be related to each other in some way. Feel free to share your "plan" with the instructor/trainers for feedback at the first onsite class. A form that could be used to work out your home study assignments plan is found at the end of this general information section.

The Timelines for the completion of each home study assignment (first time around) are listed below.

Home Study Units	# of Assignments in Each	Assignment Due Date (Postmarked by...)
#1. Introduction to Working with Preschoolers with Vision Loss in the Center-Based Setting	1	
#2. Interacting with People (language, social skills, and play with peers)	1	
#3. Use of Functional Vision; Reading Readiness	1	
#4. Braille Readiness and Listening Skills	1	
#5. Self-Care and Independence	1	
#6. Motor; Orientation and Mobility	1	
#7. Cognition and Concept Development	1	
#8. Assessment and the IEP	1	
	8	

On the average, completion of practicum-based homestudy assignments should take about four to five hours and reaction to readings type assignments three to four hours. Generally, you are given 1 1/2 to 2 weeks to complete each one. In some cases, if you are planning to combine practicum assignments from several homestudy units into one visit with a child or family in a home, care setting, or early intervention program, you may not be able to complete that particular assignment until the week when the visit is made. You should indicate this by letting your instructor/trainer know in writing which assignment you are planning to do for that unit and when you think you will be able to complete it in light of the practicum. You can turn in another assignment of your choosing on the other assignment's due date. Assignments should be sent to your instructor/trainer on a regular basis, not all at the end of the class. A point will be taken off for each week an assignment is late, up to three points. If an assignment is going to be late, call or write your instructor/trainer to set a new deadline for that assignment.

You may choose to work on an assignment in teams. It would be best if you worked with a professional from a different specialty area (e.g., vision teacher and early childhood teacher working together). You should let the instructor/trainer know about this at least two weeks ahead of time. The resulting paper would be longer. For example, if two people worked on it, the paper should be twice as long. Each should take clear responsibility for a part and work together to come up with a plan and implement it. Team members will receive a "joint" or group score for that assignment. Team members must like and respect each other if this is going to work.

You may turn in a videotape for an assignment. If so, you should let the instructor/trainer know ahead of time and include with the tape a written introduction. Use a video plan sheet that states the purpose of the tape, who is on it, how long it is, and how you want it evaluated. You should be prepared to show it to the class if there is time and the trainer feels that others could learn something from it. Prepare two questions for the audience to deal with in regards to the contents of the tape. The questions might be something like "How am I doing?", "Was I following the child's lead?". The viewing and discussion should take no more than 15 minutes. Plan to hand back in to the instructor/trainer a summary of the class discussion and synthesis of feedback given by your peers.

The homestudy assignments will be graded by using a portfolio assessment procedure. Portfolio assessment is a method by which you develop an exemplary sample of work which illustrates specific professional competencies and demonstrates that representative course objectives have been met. This process allows you to make improvements on your work, if you choose, and to receive credit for that growth. For the purposes of the VIISA courses, you must:

1. Select and complete the designated number of assignments for the given course format from the homestudy units. At least four of these assignments must be from the B list. The others can be from either the A or the B list. The A list are question/answer type assignments. The B list are hands-on activities with children, families, and service providers that must be done through the practicum (refer back to the instructions for the practicum).

2. When writing responses to the questions or assignment directives, you should cover the assignment carefully, using specific and clear responses. Reflect your own work and thinking. Don't rely on copying from the textbook. If you use the words of another, quotation marks should be used.

3. Responses to assignments should be type-written, double-spaced, or written in ink in legible handwriting on 8 1/2" x 11" paper. Papers should be proofread with ample margins on the sides and between paragraphs for the trainer's comments. If you are using a computer with a spell checker, run your paper through that spell checking program before mailing it in.

4. Special consideration should be given to neatness, grammatical construction, spelling, and punctuation.

5. All pages of each assignment should be stapled together to a yellow cover sheet (these are provided in the back of the Homestudy Manual). Name, address, course title, department, and homestudy unit and assignment number should be written in the space provided on the cover sheet. The assignment is then folded inside the yellow cover sheet and put inside an envelope. A return address should be on the envelope. The assignment is then mailed with adequate postage to the trainer at the address in front of the Homestudy Manual. You should keep a copy of your assignment in case it gets lost in the mail. If your address changes, you should let the trainer know immediately.

6. When you complete an assignment, look at the next. If you have questions about it, call your instructor/trainer or attach a note to the one you are turning in with your questions about the next one. In this way your instructor/trainer can help clarify what's being asked of you in that next assignment.

7. When each assignment is mailed to the instructor/trainer, it is considered a first draft. They will provide feedback and mail it back to you. You then have the opportunity to develop or expand on the assignment if you so choose in order to improve your grade. Retain this copy for final portfolio submission before the end of the course. Put the revised copy with the original or else indicate on the revised copy where changes were made. This will be most helpful to the instructor/trainer in grading your revisions.

8. If an assignment is not returned to you after a reasonable period, please contact your instructor/trainer.

9. Organize and mail at the end of the course the eight assignments (original with revised copies) for each of the eight homestudy units in a folder (portfolio) as a sample of your best work. The instructor/trainer will then grade and mail your portfolio back to you.

10. Most of the readings for the homestudy units will be from the text. When referring to the text in the homestudy units, the following abbreviated title is used: *Resource Manual for VI*. A copy of every article listed under "Required Readings" will be found with that unit in the Homestudy Manual.

The Practicum

Each homestudy unit has several options of practical hands-on types of experiences under the B-Assignment list. You must choose one from this B list in at least four of the required assignments.

You are required to do hands-on activities for the four chosen homestudy assignments in at least three field-based experiences, each lasting for at least one hour. In the preschool course, the practicums must take place with at least one other professional and the parents or caregiver in a center-based setting; the second with the child in their preschool setting; and if possible, the third should take place in an integrated setting. All three experiences must involve a preschooler with a visual impairment. If possible, at least one of the field-based experiences should be done with a preschooler who is totally blind and the others with a preschooler who has low vision.

You may use children with vision losses in your own local program. However, you may get the most out of the practicum experiences if you involve a variety of settings, professionals, and children. If your program or school district has a vision consultant available, you may wish to consult with them or invite them to observe or give feedback.

Keep a practicum log which includes dates, times, types of visits, locations, and contact persons. This log, along with the write-ups of practicum assignments (with trainer feedback) must be turned in with the portfolio before the end of the course. A sample log is found in their Homestudy Manual.

During the first onsite class, the instructor/trainers will discuss the practicum options and sites where children can be accessed and clarify any other questions you might have about the practicum. Participants in rural areas may need to have creative alternatives (e.g., talking on the phone with parents of a child who is blind 100 miles away; observing a child who is blind in a preschool setting on videotape). Be prepared to brainstorm viable alternatives with your instructor/trainers.

Special Accommodations

If you need any special accommodations, let your instructor/trainers know well in advance of the first onsite. These may include such things as the need for large print or braille, seating near the front of the room, accommodations for a guide dog, interpreter, or wheelchair accessibility. The VIISA text is not yet available in braille, large print, or audiotape. The VIISA Project is working on this though. If the participant has access to an IBM compatible computer, contact the VIISA Project office in Utah for the text on disc. Let the Project know if you need the material in MS DOS ASCII file or in WordPerfect 5.1 and if you prefer a 3 1/2" hard disc or a 5" floppy. The material can then be accessed through a screen reader, large print on the computer screen or on the braille display, whatever the participant has installed on their computer. The formatting is, however, not totally clean.

Your State Library for the Blind should be willing to put the Homestudy Manual into braille and record the longer articles in it for a reasonable fee. Your instructor/trainer may select some of the key transparencies and handouts used in the onsite classes to have brailled or enlarged on copy machine, depending on which reading format you prefer. You need to give them plenty of lead time, however, to get materials properly prepared!

If you don't have access to computers, consider arranging for reader services ahead of time in order to access material in the two-volume resource manual where most of the readings are found.

Sharing of Resources and Materials

You are encouraged to share experiences, resources you know about in your area and state, activity ideas and learning toys and materials with the class as they relate to the topics being discussed. Use this class as an opportunity to network with other professionals serving young children with vision impairments and their families in your state.

Grading Procedures

You are evaluated and earn points toward a final grade in several ways. One is through participation in onsite classes. Not only do you earn points by being there, but the trainer can assign additional points from a "discretionary" category to participants who share ideas and materials, get involved in discussions and take a more active role during class. You also earn points through your homestudy assignments. The instructor again can tap a "discretionary" category to add points for those whose quality of work is above and beyond what has been asked. They can also add points for those who have made the added effort of observing a variety of children with visual impairments in a variety of settings.

When reading an assignment and assigning a point value to it here are some things your instructor/trainer will be considering:

a. Content-worth a little more than 1/3 of the total points; look for how soundly your ideas and activities are based in best practice, in reflecting what you were to have read and learned, innovation, how well they fit the child, family, situation, etc.

b. Completeness-worth 1/3 of the total points; look for how well you met the intent of the assignment, thoroughness, etc.

c. Grammar/Spelling/Readability-worth a little less than 1/3 of the total points. As a professional, you should be able to share information appropriately and clearly whether spoken or written.

If you find you struggle with using correct grammar, punctuation and/or spelling, find a friend or family member with good writing skills to proof your work and give you feedback. Then, clean it up before you send it in. Sample homestudy assignments and portfolios will be available for you to look at during the first onsite class.

Format #1, Doing All the Homestudies		Format #2, Increasing Onsite Time
Course #1	Course #2	Course #1 and #2
20 attendance at onsite 1 (5 pts. for every 1/2 day; 2 days)	**20** attendance at onsite 1 (5 pts. for every 1/2 day; 2 days)	**33** attendance at onsite 1 (3 days x 11 pts.)
20 attendance at onsite 2 (5 pts. for every 1/2 day; 2 days)	**20** attendance at onsite 2 (5 pts. for every 1/2 day; 2 days)	**27** attendance at onsite 2 (2 1/2 days x 11 pts.)
30 for the reaction to reading homestudies (3 asmts. x 10 pts.)	**36** for the reaction to reading homestudies (4 asmts. x 9 pts.)	**60** for practicum-based assignments (4 assignments x 15 pts.)
60 for the practicum-based homestudies (4 asmts. x 15 pts.)	**56** for the practicum-based homestudies (4 asmts. x 14 pts.)	**10** for reading-based assignment (1 assignment x 10 pts.)
20 discretionary points (10 pts. for participation & sharing, 5 pts. for quality of work, 5 pts. for seeing a variety of children in different settings.)	**18** discretionary points (8 pts. for participation & sharing, 5 pts. for quality of work, 5 pts. for seeing a variety of children in different settings.)	**20** discretionary points (10 pts. for participation & sharing, 5 pts. for quality of work, 5 pts. for seeing a variety of children in different settings)
150 Total Points	**150 Total Points**	**150 Total Points**

Outstanding	A	96-100%	144-150 pts.
Very Good	A-	90-95%	135-143 pts.
Good	B+	87-89%	130.5-134 pts.
Fair	B	84-86%	126-130 pts.
Fair	B-	80-83%	120-125 pts.
Pass	C+	77-79%	115-119 pts.
Fail	D	76% and below	114 or lower pts.

To calculate the letter grade, just divide the total number of points (150) into the number of points you earned (e.g., 120/150 or 120 ÷ 150 = .8 or 80%). Then use the table on the preceding page to calculate the letter grade.

More points are assigned to the practicum-based assignments because they should take more time and effort. You may wish to use the blank individual gradesheet included in this section to keep track of your work. A sample gradesheet (filled-out) has been included for your reference. Your instructor/trainer will keep one on you and send you a copy at the end of the course. Note how revisions are scored. Add the first score with the second score and divide by 2 to find the average of the two. This will give you the final score for that revised assignment. In this way participants who did a good job their first time around have an edge over those who did not.

Examinations

There are no examinations.

Am I Spending Too Much Time on the Class Readings and Homestudies?

When taking the VIISA class for college credit, keep in mind that this is a course, not simply a workshop where everything is spoonfed to you. You are an active participant in this learning experience. We realize that you are a busy professional balancing full-time work and family life. If you were taking this class on campus, the time commitment would probably be even greater. Take for example a four hour course on a quarter system on campus. You would be in class 4 hours a week for 10 week = 40 hours. Generally, you should be spending at least 1 hour out of class per hour of class time doing readings and assignments. That is another 4 hours a week for 10 hours = 40 hours. A total of 80 hours should have gone into that class.

Now, let's take the VIISA class under format #1. You spend 28 hours in onsite classes; 24 hours on practicum related assignments (4 assignments x 6 hours each of observation, reading, analysis, write-up = 24 hours); 12 hours in reaction to reading assignments (3 assignment x 4 hours each = 12). That totals 64 hours plus add some time for revisions, travel to and from onsites, etc. It isn't too much after all. Working for a letter grade for credit does take time and commitment on your part. Also, courses with a letter grade transfer better between states and universities. Pass/Fail grades don't

Project VIISA
Individual Grade Sheet

Student ID# (last 4 digits of social security #)_________ Date _________

Location ____________________ Class _____________ Format ___________

Note: star the practicum related assignments.

Homestudy Unit # and Assignment # (e.g., Unit 2, B-1, Unit 7 Part 1, B-1)	First Score	Revision Needed and Made	Revised Score	Final Score	Discretionary Points

Total Points for Practicum-Based Homestudies ( ) __________

Total Points for Reactions to Readings ( ) __________

Points for Onsite 1 __________

Points for Onsite 2 __________

Discretionary Points ( )

Class Participation ( ) __________

Observed Variety of Children & Settings ( ) __________

Quality of Work ( ) __________

Total Points __________ **%** __________ **( ) Letter Grade** __________

Sample   Jan Davis

Project VIISA
Individual Grade Sheet

Student ID# (last 4 digits of social security #) 5555 Date 6/15/94

Location Hawaii Class Preschool Format all the home studies

Note: star the practicum related assignments.

Homestudy Unit # and Assignment # (e.g., Unit 2, B-1, Unit 7 Part 1, B-1)	First Score	Revision Needed and Made	Revised Score	Final Score	Discretionary Points
* Unit 1, only one assign choice	11/14 -1 because a week late so, 10/14	describe the social interactions more throughly	13/14	10+13= 23÷2= 11.5	low vision child in integrated setting +1
* Unit 2, Assign B-2	12/14	grammar errors, not carefully written	did not redo	12	blind child in non-integrated +2
Unit 3, A-1	7/9	only discussed 8 points & it asked for 10	9/9	7+9= 16÷2= 8	
* Unit 4, B-2	14/14	job well done deserves a couple extra points		14	multihand. child in non-integrated +1 +2 for job done well
Unit 5, A-2	8/9	see a few more ideas included	did not redo	8	
* Unit 6, B-1	13/14	needs to be neater, spelling/grammar errors	did not redo	13	preschool teacher of low vision child in integrated setting +1
Unit 7, Part 1, A-4	6/9	discuss results & suggests. for modifications	9/9	6+9= 15÷2= 7.5	
Unit 8, A-2	9/9	nicely done		9	+1

Total Points for Practicum-Based Homestudies (50)	50.5
Total Points for Reactions to Readings (30)	32.5
Points for On-site 1 (20)	20
Points for On-site 2 (20)	20

Discretionary Points (18)

Class Participation (8)	5
Observed Variety of Children & Settings (5)	5
Quality of Work (5)	3

Total Points 136 % 90.6 (136/150) Letter Grade A-

Other

My Home Study Assignment Plan (for student use only as a planning tool)

Name ______________________________

State ______

Four assignments chosen to do in practicum from B list. Note: Unit #, Part, Assignment # -i.e., B-1	My plan for how to fit them into at least three field-based visits, lasting at least one hour each i.e., home visit, visit with child and parents or caregiver in a center, and one with child in integrated setting if possible. The infant or toddler should be visually impaired; and if possible have one experience with child who is blind and the other two with child who is low vision (or vice versa).
1.	
2.	
3.	
4.	
5.	
6.	

Three other Assignments Chosen Note: Unit #, Part, Assignment # -i.e., A-1	
1.	5.
2.	6.
3.	7.
4.	

Practicum Log for VIISA Course

Name ______________________ State ______

Date	Time	Location	Contact Person, Parent, Child	Explanation of type of visit and/or activity

Developing a Resource File

You should develop a resource file of catalogs, pamphlets and other materials that will be helpful to you in serving families of infants and toddlers with vision loss. Here's how:

1. Carefully study Appendix A: Organizations and Resources for Families and Professionals, pp. 46-53 in the text and in the Recommended Resources list at the end of this section.

2. Send a form letter to the Parent Organizations, asking for information on the information and services they provide. Tell them you are a professional who works with a VI child.

3. Send a form letter to the organizations under Research and Publications, asking for a copy of their educational products and publications catalog.

4. Choose and order some of the less expensive pamphlets and booklets listed under Reading Material for Parents. An order blank for the Blind Children's Center pamphlets is included in this section. These pamphlets are excellent, inexpensive and should be high priority on your list. A few other order forms have been included. The PAVII manual should also be purchased.

5. Consider getting on the mailing list of the National Newspatch, a newsletter full of wonderful ideas for educators of preschoolers with vision loss. It costs just $4 for two issues a year. A subscription form is enclosed for your use.

6. Search out the vision resources available in your local area and state. Your local itinerant teacher for the visually impaired, State School for the Blind, etc. can be of help.

7. As the course progresses, you will be seeing some of the excellent media and books listed on the Recommended Resources list for VIISA. You might want to make note of the ones you liked best and encourage your local agency or regional resource library to purchase some for use wit families of young children with vision loss.

8. This resource file project can be ongoing throughout the course. You will learn about other materials in subsequent home study units. For example: companies with catalogs to order large print and braille books for preschoolers.

APPENDIX F

Training State Instructors

Evaluation Summaries from Demonstration Sites

Evaluation of VIISA Trainers' Training
Ohio

1. What were the best aspects of this training session?

    1. Amount of material covered and degree to which it was organized. Also, presenters knowledge of content.
    2. Going over the manuals and pointing out specifics. The "walk through". Being with each other.
    3. The class was very organized.
    4. Sharing ideas and encouragement, talking through the curriculum. I have taught many courses and workshops and have never had any training in teaching adults. It has always been on my own.
    5. Training and resources were very comprehensive. Resources were excellent.
    6. Experience of the national trainer very helpful in not having to "re-invent the wheel." Her familiarity with materials.

2. How could it have been improved?

    1. Blank
    2. Heat on Saturday.
    3. Perhaps seeing overheads and handouts as they were discussed.
    4. It was very helpful and was very well organized.
    5. None noted
    6. If Ohio level decisions were further along, but the wheels move slowly!

3. What are the strengths of the workshop facilitator?

    1. Flexibility. Willingness to allow input from others.
    2. Allows for discussion, keeps us moving, and covered lots of topics well.
    3. Organization, skill with people, a wonderful, joyful person.
    4. Encourager. Sheri has the nicest personality and she seems to really enjoy what she does.
    5. Materials were complete and provided ahead of time for reviewing.
    6. Familiarity with materials. Experience in working with adults. Experience in teaching the course.

4. What were the weaknesses of the workshop facilitator?

    1. No observable weaknesses.
    2. None
    3. Doesn't like tofu.
    4. None
    5. None noted
    6. Blank

5. How did you feel about the facilities and arrangements for the workshop?

   1. Adequate.
   2. They were good. Room on Saturday was cold.
   3. Very nice.
   4. No problems.
   5. Excellent planning, no difficulties.
   6. Good, except the meeting room was cold! Hotel was great and arrangements all smoothly done ahead.

6. What are the strengths and weaknesses of the VIISA Trainers' Manual?

   1. Voluminous to a fault, but well organized.
   2. Excellent. Well thought out. Lots of materials and information.
   3. Perhaps manuals could be separated into smaller books easier to handle.
   4. Very comprehensive. I cannot believe the amount of material that you have compiled.
   5. Strength is completeness of program coverage of the amount of materials.
   6. All strengths: Quality of information. Accuracy and organization. Completeness of information of materials.

7. Do you feel prepared to assist in conducting VIISA training? Why or why not?

   1. Yes, breadth of experience and familiarity with course content.
   2. Yes.
   3. The instruction is very appropriate. I was a little overwhelmed by the massive amount of information presented, but I am sure once I go over this privately, I will fell more comfortable.
   4. Yes. I feel very comfortable with this material.
   5. I feel materials were well ordered. Very helpful suggestions were provided for how to cover a massive amount of materials. Materials and many helpful hints were provided.
   6. Yes. Co-teaching is very supportive and materials are so well designed and organized.

Evaluation of VIISA Trainers' Training
Missouri

1. What were the best aspects of this training?

    1. Deborah was great, as usual. Good materials from SKI*HI.
    2. Being with other professionals from another region. Getting a format/structure for the training.
    3. Materials were presented with seriousness, but with an appropriate element of humor. Very enjoyable!
    4. Having Deborah Chen here to guide us. Beginning to be a team, getting to know each other.
    5. Delightful, humorous group. All inclusive.
    6. Group discussion, reflection, instructor's type and experience.
    7. Colleagues sharing. Knowledge/comfort level of instructor. Size of group.
    8. The teacher was outstanding.
    9. Brainstorming. Reviewing videos and strategies. Chance to meet team members.

2. How could it have been improved?

    1. Blank
    2. I enjoyed all of it.
    3. No improvements recommended.
    4. Blank
    5. It was fine.
    6. I can't think of anything.
    7. No way I can think of.
    8. The twelve hour day was very hard.
    9. Blank

3. What are the strengths of the workshop facilitator?

    1. Great knowledge base.
    2. Very knowledgeable and able to relate the material based on the meeds of the group. Flexible/responsive to individual needs.
    3. Knowledge of "everything" in the vision field. Very personable.
    4. Her knowledge, and comfortable presentation style, gifted facilitator.
    5. Sense of humor. Broad experience with content and teaching. Expert of expert.
    6. Experience, practical examples, facilitating style.
    7. Knowledge/comfort level and respect of participants. Everything really. I couldn't imagine being any more comfortable.
    8. A lot of good stories and experiences.
    9. She's excellent. We will never actually replicate, but will try to use her techniques: Open-ended questioning, encouragement, good feedback, able to refer to variety of resources.

4. What were the weaknesses of the workshop facilitator?

    1. Blank
    2. Blank
    3. None
    4. Blank
    5. None
    6. None
    7. None that I was aware of.
    8. N/A
    9. None

5. How did you feel about the facilities and arrangements for the workshop?

    1. VCR placement and functioning could be better, but wasn't a bid deal. Good food, tables fine.
    2. Fine. The food was great. The hospitality was greater.
    3. Great!
    4. Excellent.
    5. O.K. Not terribly fond of the Dorm. Food was great!
    6. Worked for me.
    7. No problem, comfortable. Above and beyond for food quality!
    8. Great.
    9. Excellent.

6. What are the strengths and weaknesses of the VIISA Trainers' Manual?

   1. Blank
   2. Looks great. Will want to work with it more before providing one.
   3. Strength: Good materials. Weakness: Some copies are poor and hard to read.
   4. Good resources, seems to be thorough.
   5. Strength: Recipe book. Weakness: Overwhelming on first encounter.
   6. Good outline, resources, examples.
   7. Strengths: Organization and comprehensiveness. Weaknesses: Some pages of referential materials have streaks or areas cut off, but not illegible.
   8. Weaknesses: Some of photo copies are poor quality.
   9. Good manual! I'll know more after using it once.

7. Do you feel prepared to assist in conducting VIISA Training? Why or why not?

   1. Pretty much.
   2. I will by Friday.
   3. Yes. There's lots of materials, so lots to learn and cover. However, with all the materials provided in the manuals, it will be much easier to prepare. Grading the home studies will be the most difficult for me.
   4. Yes. With lots more preparation, reading and teaming.
   5. Yes. With qualification. It will take considerable time for preparation.
   6. Yes, and I will.
   7. Yes. I believe because of this weekend. It was very productive. I did not feel that way two days ago.
   8. Yes.
   9. We will see...I do hope so.

Evaluation of VIISA Trainers' Training
Louisiana/South Carolina

1. What were the best aspects of this training?

    1. Small group, excellent instructor.
    2. The materials and the opportunity to discuss with others were the best aspects for me.
    3. Tailored to meet the needs of the group, changes were made as needed.
    4. Sharing with other professionals. New information in manuals and handouts.
    5. It was relaxed and informal.

2. How could it have been improved?

    1. I thought it was excellent.
    2. It would have been helpful to have received the materials in advance. However, I have been reading and rereading the articles, etc.
    3. Training Tapes to remain in South Carolina to be viewed by participants.
    4. Additional materials presented to workshop in a more organized form.
    5. Blank

3. What are the strengths of the workshop facilitator?

    1. Outstanding knowledge of material. Wonderful ability to share her knowledge.
    2. The facilitator is very low key and encouraged the participants to discuss and ask questions.
    3. Knowledgeable and flexible.
    4. Hands on experience. Breadth of knowledge, especially medical. Personable nature.
    5. She is knowledgeable of the information, fair, and encouraging.

4. What were the weaknesses of the workshop facilitator?

    1. Blank
    2. With a confident group. Her style is fine but with a less confident or knowledgeable group, her style might not be helpful. However, she may have adjusted to our learning styles.
    3. Blank
    4. Allowed group focus to wander occasionally.
    5. Blank

5. How did you feel about the facilities and arrangements for the workshop?

   1. Everything was above average.
   2. The facilities and arrangements were satisfactory. The host participants were very congenial.
   3. Adequate.
   4. Excellent.
   5. They were excellent.

6. What are the strengths and weaknesses of the VIISA Trainers' Manual?

   1. Some pages missing. They have been replace now.
   2. The manual covers extensive material. It's very difficult to name a weakness.
   3. Not indexed with PA Manual.
   4. Organization: Hard to find things.
   5. It contains a lot of excellent materials. Some of the copies are difficult to read.

7. Do you feel prepared to assist in conducting VIISA Training? Why or why not?

   1. Yes. Trainer's Training answered my concerns.
   2. Yes. I feel I can conduct VIISA training with assistance of another co-presenter with a strong background in the field of visual impairments. I personally have a strong background in early childhood education (both regular and special education) as well as working with families.
   3. Yes. As soon as the video and book library are completed I'll feel better.
   4. Yes. Still a little unclear about how to know what to cover and organization of material presented.
   5. I hope so. It seems a little overwhelming right now and I have a lot of work to do.

Florida
Debbie Gleason
Sept. 94

Evaluation of VIISA Trainers' Training

1. What were the best aspects of this training session?

    1. I really liked all the new information and expanded sections.
    2. The opportunity to share ideas, information, and hear different views on each topic.
    3. The ideas for working with adult learners and all of the input/suggestions for the topics.
    4. The camaraderie, the fact that some concerns I mentioned on the opening interview were addressed and were viewed as strengths by others. It was a cohesive group and I think a strong team. Each person responsible to cover their parts.
    5. The valuable inside information shared from other professionals. The feeling of being comfortable teaching VIISA. Very productive and comfortable.

2. How could it have been improved?

    1. I don't feel as if this training needs to be improved.
    2. I felt okay with everything.
    3. Can't think of anything at this time.
    4. Perhaps thinking about the check out time ahead, but it was really not a big deal.
    5. Number the tabs for topics so they are easier to reference.

3. What are the strengths of the workshop facilitator?

    1. I feel Debbie is very knowledgeable and seems very receptive to all the questions and comments.
    2. Easy to work with. Very supportive and considerate. Very thorough.
    3. Debbie has a great ability to share information. she has a very positive and pleasant delivery method.
    4. Willingness to adjust the schedule as best suited the group. Taking down our questions and assuring they were addressed by the proper people (Bess, Kathleen, Deb). Making all of us feel respected and that we each are important members of the team. Drawing on our strengths and acknowledging that including many of our ideas is a good thing. She also is well read in current research, shares that information graciously. Deb is always prepared and extraordinarily helpful.
    5. Organized. Willing to utilize participants experiences. Non judgmental. Relaxed format. Flexible with the time breakdown of the hours.

4. What were the weaknesses of the workshop facilitator?

   1. None.
   2. Blank
   3. None.
   4. Weaknesses? None identified.
   5. Blank.

5. How did you feel about the facilities and arrangements for the workshop?

   1. The facilities were very nice, no complaints here.
   2. I thought the hotel was nice and it was so comfortable to do the workshop in such a homey atmosphere. I wish they had a clock in the room, though.
   3. Facilities excellent! I enjoyed being able to stay in one place.
   4. Great facility, but can you halt the construction? I believe I had plenty of lead time in terms of arrangements.
   5. Facilities and arrangements excellent! Beautiful, comfortable. Sharing a room was a great opportunity to get to know the other members better. Organized.

6. What are the strengths and weaknesses of the VIISA Trainers' Manual?

   1. I feel the VIISA Program was very well thought out and the manuals are put together in an easy to use format.
   2. I liked how everything was laid out and that transparencies, handouts, and resources were grouped with the topic. They look like they will help with making the planning easier. There were a few minor mistakes and a page for instructor notes in each section would have been nice, but this can be added by the instructor.
   3. The manuals are very complete and well organized.
   4. Most of the weaknesses we noted as we went through the sections. The strength is its comprehensive nature and the checklists for putting together a training. Including Home Study Manuals - good.
   5. Strengths -- Volumes of wonderful information, well organized by topic, I like the way one day workshops can be pulled.
      Weaknesses -- Need tabs to identify Home Study Manual units in Vol. #, Color tab and have tabs stick out on main teaching categories.

7. Do you feel prepared to assist in conducting VIISA training? Why or why not?

    1. Yes. I feel that I will be able, with all these materials, to assist in conducting a VIISA workshop.
    2. Yes, I feel like we have a good group to work with and that everything I need will be listed in the manuals. We have a diverse group in which each of us is strong in certain areas, so we will be a good resource for each other during planning.
    3. Yes, I feel comfortable with the majority of the topics in the course.
    4. Yes, ready to assist, able to present some topics. Matching with co-trainer important consideration. Still have some concerns about time, place, etc.
    5. Blank.

Course Evaluation VIISA Trainers' Training
Iowa

1. What were the best aspects of this training session?

- Review of Materials, Resources. Sharing with each other. Building Teams.
- Review of Information.
- Manual very thorough and complete, sharing with one another.
- Discussion, group problem solving.
- Review of information. Getting back together. Reviewing videos.
- The sharing of ideas and materials was great.
- Getting together to go over the units and share experiences.
- Review of videos. Instructors' manual and articles!!! Great materials!!!
- The time to view videos, preview materials, get comfortable with the manuals.
- Good to get together with others to find out about some same/different concerns and questions.

2. How could it have been improved?

- N/A
- Two days instead of three.
- ??
- Not sure. Seemed long at times.
- (question left blank)
- I can't imagine. Looks great as is now.
- (question left blank)
- Unsure at this time.
- I don't have any suggestions.
- This was good - more prep time for getting classes organized in state.

3. What are the strengths of the workshop facilitator from Utah?

- Flexibility. Knowledge Base. Willingness to meet our needs.
- Knowledge of subject.
- Organized, Knowledgeable.
- Good discussion leader, lent perspective to the group.
- Very helpful. Needed her to pull it together and re-focus.
- Very knowledgeable. Very prepared. Very nice delivery. Good suggestions.
- Very knowledgeable. Good balance of letting us share but also keeping us on tasks.
- Thorough, well prepared, knowledgeable, helpful and all that good stuff.
- Laid back attitude; depth of knowledge.
- Knowledge of instructor excellent.

4. What were the weaknesses of the workshop facilitator from Utah?

- None.
- Caution or infringing (?) on disciplines.
- ??
- None, she was good.
- None.
- Can't see or think of any.
- (question left blank)
- None.
- None.
- None.

5. How did you feel about the facilities and arrangements for the workshop?

- (picture of an unhappy face) Sorry!
- Bugs.
- I didn't like the cockroaches or the thermostat.
- Too many bugs!
- Don't ever stay at Howard Johnson again.
- Okay, but didn't care for the bugs.
- Could have been better.
- Great bugs. Daryl, Daryl, and Daryl were okay, too!
- Yikes!
- Hotel was not very nice.

6. What are the strengths and weaknesses of the VIISA Trainers' Manual?

- Excellent. Well Organized.
- Basically good. Like resource information available.
- The manual is excellent.
- Good materials and support.
- Great!!
- Okay. Pages missing were made up.
- Good information included and good organizational pages.
- Absolutely great materials and manuals!!! A few pages missing, but that happens.
- The manual is extremely well organized.
- Great information, very organized and put together well.

7. Do you feel prepared to assist in conducting VIISA training? Why or why not?

- Yes.
- Yes. Felt so before these sessions.
- Yes, but I am concerned about fitting all of the information into the time limits we'll be working with.
- Yes!
- Yes!
- Yes, and especially since I have manuals, materials, access, etc.
- Yes with a lot of preparation and meeting with the National Trainer.
- There is a need to read and integrate all the materials (in depth) in own learning style before a comfort level can be attained. Still, many questions of how, when, and where to implement; although the vision appears more clear now! Anxiety level is dropping!
- Yes, because I feel it is so important.
- Possibly, just need to get more clarification from team members about what we are going to do.

APPENDIX G

VIISA Management Manual: Table of Contents

Project VIISA
(Vision In-Service in America)

Management Handbook for Coordinating Agencies Implementing the VIISA Model Inservice for Early Intervention/Early Childhood Professionals Serving Infants, Toddlers, and Preschoolers Who are Blind and Visually Impaired

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Note: For the sake of brevity in this manual, the term "children with visual impairment(s)" is frequently used to refer to both children who are blind and children with varying amounts of vision. Also, the national staff person assigned to work with a state by the VIISA project may be referred to as the VIISA Instructor or VIISA Site Coordinator/Course Consultant, usually the latter. Local trainers are the professionals you select to conduct your state's VIISA training sessions or classes.

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APPENDIX H

Follow-up Survey to Participants in the Demonstration Sites

Dear VIISA Participant,

I hope each of you had a nice Christmas and New Years holiday and are back to work refreshed. As the VIISA Model Inservice Project comes to a close, we are in need of some follow-up evaluation information from those who participated in the VIISA courses over the past 3 years. Last spring, when we mailed you your certificate for completing the VIISA class (or classes), we included the enclosed questionnaire, but received very few back. So, we are trying one more time.

Funding for this type of federal grant is in jeopardy under the new administration. If you in any way appreciated the opportunity this project gave you to further knowledge and skills in a low incidence disability area, then please take the time to fill the questionnaire out. Mail it back to me ASAP in the attached self-addressed stamped envelope.

I am asking you to take a few minutes to reflect upon the training you received through the VIISA project and to provide us with some important feedback about the usefulness of the materials, skills and information gained through the training. Thank-you for your time.

Sincerely,

Elizabeth C. Morgan
Director, Project VIISA

Enclosure

ECM/db

PROJECT VIISA FOLLOW-UP QUESTIONNAIRE

Please complete and return this form to Elizabeth Morgan at the SKI*HI Institute in the attached envelope as soon as possible. Thank-you. A current mailing address and work phone number are being requested so that we can keep you on our newsletter mailing list.

National Summary **10 states returned 107 out of 200**

1. How many children (ages 0-5 years) with blindness and visual impairment are you presently serving? 356 Please list below the ages, degrees of vision impairment, and additional disabilities. For example: one 2 year old, totally blind with motor problems; one 9 month old with low vision and no other disabilities....

Birth to 3	3 to 5	low vision	legally blind	totally blind
166	190	92	44	42

multi-impaired (autism, microcephaly, hydrocephaly, CP, cognition, developmental delays, syndromes like Downs, Charge, Marfus, Trisomy 12 & 18, motor, speech & language, health autism, abuse, head injury, seizures, Wilmus tumor, stroke, deafness, ADD, prematurity 52%

CVI(74) ROP(20) Albinism(8) Strabismus(7) high refractive error(6) cataracts(6) Downs(4) septo optic dysplasia(3) optic nerve atrophy(3) glaucoma(2) Lebers(7) anophthalmia(2) optic nerve hypoplasia(2) nystagmus(1) aniridia(1) microphthalmia(1) Charge(1) tumor(1)

2. Has the training you received through VIISA helped you improve upon the services you provide to these children and their families?
93 yes ___ no If yes, how?

In summary, those people trained now have a greater awareness of visual impairments and feel they can understand the children's perspective better. They are more comfortable with home intervention and providing information for parents. They also feel better educated to help teachers.

3. What materials, skills, or information have you used the most from your VIISA training during the past year?

Those trained use all the information provided including the manuals but information used more often are the handouts, programs and helps for parents, assessment areas, activities, lesson plans, and the orientation and mobility, grief, and medical sections.

4. What areas have you found your VIISA training to be most lacking in as you work to provide intervention services to young children with blindness and visual impairment and their families and/or local preschool programs?

The areas that seemed most lacking were functional vision assessments, integration strategies, counseling with parents, information on discipline problems, and information on multiple-impaired children

5. What changes and improvements would you like to see made to the VIISA training format, content, and materials?

Along with the topics mentioned above it was also felt that the manual could have been put together by proofreading and having pull out handouts for the parents. Most feel a follow-up course is needed. Some feel a combined VIISA and Insite course would be useful. All feel there was a lot of information to cover in too short of time.

6. Would you like to have an opportunity to get together with other people who have been through the VIISA training in your state for more sharing of ideas as well as to receive more training?

_78_ yes _10_ no How often? **1x/yr(29) 2-4xyr(26)**

For how long? **1/2-1 day(39) 2 days(17) weekend(10)**

Check the activities you would like to see happen at such a session.

_58_ time to network

_84_ time to share ideas, materials and strategies for working with young children with vision impairment and blindness

_54_ time to review video footage of some of the children we are serving so as to obtain intervention ideas from each other

_57_ presentations on specific topics (i.e., orientation and mobility, functional vision); list topics of interest below

PROJECT VIISA FOLLOW-UP QUESTIONNAIRE

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Summary of **Colorado** # Returned: 12

1. How many children (ages 0-5 years) with blindness and visual impairment are you presently serving? 46 Please list below the ages, degrees of vision impairment, and additional disabilities. For example: one 2 year old, totally blind with motor problems; one 9 month old with low vision and no other disabilities....

Birth to 3	**3 to 5**	**low vision**	**legally blind**	**totally blind**
13	33	12	3	4

multi-impaired (CP, hearing, cognitive, near drowning, Marfan syndrome, motor,speech)
37

CVI(15) anophthalmia(1), optic nerve hypoplasia(1), albinism(2), strabismus(3) ROP(3)

2. Has the training you received through VIISA helped you improve upon the services you provide to these children and their families?
 11 yes ___ no If yes, how?

experience of others was helpful, greater awareness of VI, learned appropriate toys and books, more comfortable with home intervention and helping parents(3), suggestions for classroom teachers, functional motor skills, visual stimulation, team planning, appropriate wait time

3. What materials, skills, or information have you used the most from your VIISA training during the past year?

handouts(6), touch cues(2), cognitive development(2), warning signs(2), programs for parents(3), activities(4), braille, Volume 2,

use it all daily(2)

4. What areas have you found your VIISA training to be most lacking in as you work to provide intervention services to young children with blindness and visual impairment and their families and/or local preschool programs?

neurological, integrated settings--techniques and strategies(2), functional vision assessment(2), severe behavioral disorders, lack of interest in school district

5. What changes and improvements would you like to see made to the VIISA training format, content, and materials?

information on multi-handicapped(2), follow-up class, reports of results, more hands on experiences, assessment, actual therapists and children, didn't like "script" format, teams representing agencies who provide services

training was complete, no changes

6. Would you like to have an opportunity to get together with other people who have been through the VIISA training in your state for more sharing of ideas as well as to receive more training?

_10_ yes _2_ no How often? **1x/yr(1) 2x/yr(7) monthly(1) 4x/yr(1)**

For how long? **1 day(3) 2 days(1) few hours (2) weekend(1)**

Where? **Denver, Colorado Springs(3), Central location in state(1), by city(1)**

Check the activities you would like to see happen at such a session.

_7_ time to network

_8_ time to share ideas, materials and strategies for working with young children with vision impairment and blindness

_8_ time to review video footage of some of the children we are serving so as to obtain intervention ideas from each other

_8_ presentations on specific topics (i.e., orientation and mobility, functional vision); list topics of interest below

wish class was offered more often, helped improve services, functional vision-screening(2), functional mobility skills, sequencing and object cues

PROJECT VIISA FOLLOW-UP QUESTIONNAIRE

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Summary of **Florida** # Returned: **13**

1. How many children (ages 0-5 years) with blindness and visual impairment are you presently serving? 61 Please list below the ages, degrees of vision impairment, and additional disabilities. For example: one 2 year old, totally blind with motor problems; one 9 month old with low vision and no other disabilities....

Birth to 3	**3 to 5**	**low vision**	**legally blind**	**totally blind**
32	**29**	**30**	**6**	**10**

multi-impaired (health, motor, trisomy(18&12), microcephaly, CP, seizures, hearing,
32 development delay, cognitive)

CVI(7) nystagmus(1), Lebers(1), ROP(2), albinism(2), cataracts(3),

Social Services work with 35 children birth to 5 who are 80% multi-handicapped

2. Has the training you received through VIISA helped you improve upon the services you provide to these children and their families?
13 yes ____ no If yes, how?

new ideas to use with children and families(2), IEP's are more individual, CVI and Lili's to use with children and families, child development, improved ability to provide emotional support

3. What materials, skills, or information have you used the most from your VIISA training during the past year?

parent discussions and diagrams, developmental charts, CVI info. and Lili Nielsen, premature infant section, grief section, functional vision explanation and diagrams, cognitive intervention, activities and lesson plans, manual(4)

use it all daily(2)

4. What areas have you found your VIISA training to be most lacking in as you work to provide intervention services to young children with blindness and visual impairment and their families and/or local preschool programs?

results of Little Room, strategies for CVI, integration strategies, behavior problems, cassette inservices, O&M, functional vision assessment, appropriate activities and toys, development of IFSP, positioning of multi-impaired children

5. What changes and improvements would you like to see made to the VIISA training format, content, and materials?

vision stimulation activities, proofread manual, pull out parent handouts(3), a lot of information in a short time(2),

training was good, no changes

6. Would you like to have an opportunity to get together with other people who have been through the VIISA training in your state for more sharing of ideas as well as to receive more training?
_9_ yes _1_ no _1_ maybe How often? **1x/yr(8) 2x/yr(4) 4x/yr(1)**
For how long? **1 day(7) 2 days(7) weekend(1)**

Where? **Central location in state(2), St. Augustine(4), Pensacola, Tampa, Orlando, FSDB**

Check the activities you would like to see happen at such a session.
_6_ time to network
_9_ time to share ideas, materials and strategies for working with young children with vision impairment and blindness
_6_ time to review video footage of some of the children we are serving so as to obtain intervention ideas from each other
_5_ presentations on specific topics (i.e., orientation and mobility, functional vision); list topics of interest below

practice information on functional vision assessment, learning media, sharing ideas, "at-risk" birth, toys, testing materials, adaptive equipment, "Little Room", low vision aids, make and take

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Summary of **Georgia** # Returned: **14**

1. How many children (ages 0-5 years) with blindness and visual impairment are you presently serving? 29 Please list below the ages, degrees of vision impairment, and additional disabilities. For example: one 2 year old, totally blind with motor problems; one 9 month old with low vision and no other disabilities....

Birth to 3	3 to 5	low vision	legally blind	totally blind
7	22	6	4	7

multi-impaired (stroke, CP, motor, cognitive, speech, hearing, autism, Wilms tumor, seizures) 20

CVI(6), optic nerve hypoplasia(1), strabismus(1), aniridia(1), ROP(3)

2. Has the training you received through VIISA helped you improve upon the services you provide to these children and their families?
12 yes ___ no If yes, how?

parent involvement, more familiar with information, education strategies, resources, ideas and handouts are wonderful, now work effectively with orientation and mobility, provide information regarding implications related to medical conditions, more appropriate services, focus on developmental level of child, eye disorders

3. What materials, skills, or information have you used the most from your VIISA training during the past year?

assessment areas, infant toys, referred parents to resources(2), forms of light, materials from "The National Lighthouse for the Blind", medical section, how to adapt materials, equipment and rooms, both volumes, activities, lesson plans, agency resource contacts, videos, notebooks(2), textbooks

all materials(3)

4. What areas have you found your VIISA training to be most lacking in as you work to provide intervention services to young children with blindness and visual impairment and their families and/or local preschool programs?

lack of time to follow-up, accurately assessing multi-handicapped, PT consultation, functional vision assessment, more information on working with multi-disabled children, activity suggestions, technical skills, addressing motor impairments, counseling with parents, more information on feeding problems

5. What changes and improvements would you like to see made to the VIISA training format, content, and materials?

update class, hands-on, service plan, pediatric ophthalmologist information, utilize vision teachers differently, provide video assessments, case-work profile, family problem solutions, separate assignments for VI teachers, physical disabilities information, list of professionals in area, multi-handicapped information, a lot of information in a short time

6. Would you like to have an opportunity to get together with other people who have been through the VIISA training in your state for more sharing of ideas as well as to receive more training?

_11_ yes _1_ no _1_ maybe How often? **1x/yr(9) 2x/yr(3)**

For how long? **1 day(6) 2 days(3) weekend(2)**

Where? **Atlanta(3), Macon(1), central location, somewhere with less travel**

Check the activities you would like to see happen at such a session.

_8_ time to network

_9_ time to share ideas, materials and strategies for working with young children with vision impairment and blindness

_4_ time to review video footage of some of the children we are serving so as to obtain intervention ideas from each other

_9_ presentations on specific topics (i.e., orientation and mobility, functional vision); list topics of interest below

functional vision--ACC assessment with young children, weekend retreat with others in training, O&M, working with other VI professionals, eye reports, support groups, multi-handicapped and blind children

PROJECT VIISA FOLLOW-UP QUESTIONNAIRE

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Summary of **Iowa** # Returned: **12**

1. How many children (ages 0-5 years) with blindness and visual impairment are you presently serving? 33 Please list below the ages, degrees of vision impairment, and additional disabilities. For example: one 2 year old, totally blind with motor problems; one 9 month old with low vision and no other disabilities....

Birth to 3	**3 to 5**	**low vision**	**legally blind**	**totally blind**
15	**18**	**10**	**4**	**4**

multi-impaired (CP, ADD, shaken baby, microcephaly, hydrocephalus, motor,speech)
14

CVI(6) optic atrophy(1) high refractive error(1) albinism(3) glaucoma(1) cataracts(1) microphthalmos(1) strabismus(1) ROP(2)

(State preschool vision consultant has 80 children birth to 5 on their database)

2. Has the training you received through VIISA helped you improve upon the services you provide to these children and their families?
 8 yes ___ no If yes, how?

made me more comfortable working with babies in their homes, materials are conclusive and easy to copy for families, more familiar with VI's and effects on development, more confident in working with preschool and infants, great explanations & drawings in manual

3. What materials, skills, or information have you used the most from your VIISA training during the past year?

resource guides, eye diagrams(3), evaluation/assessment skills, notebooks, charts(2), handouts(2), used all of the information

4. What areas have you found your VIISA training to be most lacking in as you work to provide intervention services to young children with blindness and visual impairment and their families and/or local preschool programs?

mis-spellings & typos, more time to cover information, follow-up training, functional assessments, more people need to be trained(2),

manual was great(2)

5. What changes and improvements would you like to see made to the VIISA training format, content, and materials?

additional references, part of training(videos) could be done without travel, combined VIISA & INSITE course(2), proofread text(2),

training was complete, no changes

6. Would you like to have an opportunity to get together with other people who have been through the VIISA training in your state for more sharing of ideas as well as to receive more training?
_7_ yes _1_ no How often? **1x/yr(8) 1 every other year(1)**
For how long? **1 day(8) 2 days(3) few hours (1)**

Where? **NTAEA, Central, Hawaii, Des Moines(3), Ames(2),**

Check the activities you would like to see happen at such a session.
_9_ time to network
_11_ time to share ideas, materials and strategies for working with young children with vision impairment and blindness
_10_ time to review video footage of some of the children we are serving so as to obtain intervention ideas from each other
_8_ presentations on specific topics (i.e., orientation and mobility, functional vision); list topics of interest below

activity planning, assessments, follow-up class, O&M, appropriate learning medium

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Summary of **Louisiana** # Returned: **13**

1. How many children (ages 0-5 years) with blindness and visual impairment are you presently serving? **41** Please list below the ages, degrees of vision impairment, and additional disabilities. For example: one 2 year old, totally blind with motor problems; one 9 month old with low vision and no other disabilities....

Birth to 3	**3 to 5**	**low vision**	**legally blind**	**totally blind**
16	**25**	**7**	**1**	**6**

multi-impaired (CP, prematurity, motor, hearing)
24

types of impairments:(CVI(6), cataracts(1), albinism(1), ROP(2), strabismus(2), detached retinas(1)

2. Has the training you received through VIISA helped you improve upon the services you provide to these children and their families?
11 yes ___ no If yes, how?

classes and texts were stimulating, more educated on courses and possibilities for VI children, functional vision, special concerns of VI, learned to focus on student's needs, informed consultant for teachers, confident in sharing information with families

3. What materials, skills, or information have you used the most from your VIISA training during the past year?

information for parents(3), textures, handouts, O&M, pre-braille, basic child development, videos(2), textbook(2), working with children, need and importance of giving children exposure to movement and spatial relationships, resources list(2), philosophy and practical applications, medical information

4. What areas have you found your VIISA training to be most lacking in as you work to provide intervention services to young children with blindness and visual impairment and their families and/or local preschool programs?

visual aids, refresher course, more personal contact with instructor

5. What changes and improvements would you like to see made to the VIISA training format, content, and materials?

not enough time to explore topics in greater depth, assessment, little information on serving preschoolers in noncategorical classes, lack of experience, means to get proper visual evaluations to identify areas of strength to work with parents, take the iterant VI teachers into consideration, vision stimulation

6. Would you like to have an opportunity to get together with other people who have been through the VIISA training in your state for more sharing of ideas as well as to receive more training?

_10_ yes ____ no How often? **1x/yr(3) 2x/yr(3) once a semester(2)**

For how long? **1 day(2) weekend(3) 2 days(1)**

Where? **New Orleans, Baton Rouge, central location(3), LSVI**

Check the activities you would like to see happen at such a session.

_10_ time to network

_11_ time to share ideas, materials and strategies for working with young children with vision impairment and blindness

_9_ time to review video footage of some of the children we are serving so as to obtain intervention ideas from each other

_8_ presentations on specific topics (i.e., orientation and mobility, functional vision); list topics of interest below

functional vision, new materials, new resource/reference materials, curriculum integration, writing appropriate IEP's or IFSP's, blind role models

"I plead with the funding source - not to discontinue these types of classes. It is very informative and convenient for working moms and professionals."

PROJECT VIISA FOLLOW-UP QUESTIONNAIRE

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Summary of **Massachusetts** # Returned: 2

1. How many children (ages 0-5 years) with blindness and visual impairment are you presently serving? 14 Please list below the ages, degrees of vision impairment, and additional disabilities. For example: one 2 year old, totally blind with motor problems; one 9 month old with low vision and no other disabilities....

Birth to 3	**3 to 5**	**low vision**	**legally blind**	**totally blind**
10	**4**	**7**	**4**	**2**

multi-impaired (developmental delay, motor, hearing) 2

CVI(2) Lebers(2)

2. Has the training you received through VIISA helped you improve upon the services you provide to these children and their families?
2 yes ____ no If yes, how?

greater range of service and knowledge about preschool blind children for teachers and families

3. What materials, skills, or information have you used the most from your VIISA training during the past year?

teacher and films, manual, family activities

4. What areas have you found your VIISA training to be most lacking in as you work to provide intervention services to young children with blindness and visual impairment and their families and/or local preschool programs?

more information on handling discipline problems, practical materials to use with everyday preschool projects, amount of service child should get

5. What changes and improvements would you like to see made to the VIISA training format, content, and materials?

6. Would you like to have an opportunity to get together with other people who have been through the VIISA training in your state for more sharing of ideas as well as to receive more training?

_2_ yes ___ no How often? **1x/yr(1) 2-4x/yr(1)**

For how long? **1/2-1 day(1) few hours (1)**

Where? **Perkins**

Check the activities you would like to see happen at such a session.

_1_ time to network

_2_ time to share ideas, materials and strategies for working with young children with vision impairment and blindness

_2_ time to review video footage of some of the children we are serving so as to obtain intervention ideas from each other

_1_ presentations on specific topics (i.e., orientation and mobility, functional vision); list topics of interest below

function vision assessment, assessments EI's use, amount of service required

PROJECT VIISA FOLLOW-UP QUESTIONNAIRE

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Summary of **Missouri** # Returned: **10**

1. How many children (ages 0-5 years) with blindness and visual impairment are you presently serving? 81 Please list below the ages, degrees of vision impairment, and additional disabilities. For example: one 2 year old, totally blind with motor problems; one 9 month old with low vision and no other disabilities....

Birth to 3	3 to 5	low vision	legally blind	totally blind
58	23		2	2

multi-impaired (CP, intellectual brain injury, trisomy(9), speech, motor)
25

Types of impairments: (ROP(5), CVI(23), high refractive error(1), Lebers(1), anophthalmia(1), optic atrophy(2), Septo Optic Dysplasia(3)

2. Has the training you received through VIISA helped you improve upon the services you provide to these children and their families?
 9 yes ___ no If yes, how?

more confident and relaxed working with parents(2), better understanding development of young VI children(3), more practical information on facilitating child's independence, know resources better(1), understand reports better(1)

3. What materials, skills, or information have you used the most from your VIISA training during the past year?

practical information from lectures(2), use resource manuals frequently(3), VIISA reinforced my ideas and values about working with the VI kids, used self-help information the most, work with families(2), functional assessment of skills and adaption of materials(2), medical terms(1), adapt materials(1)

4. What areas have you found your VIISA training to be most lacking in as you work to provide intervention services to young children with blindness and visual impairment and their families and/or local preschool programs?

none(5), more information on multiple impaired, assessment procedures, more time on IEP goals, more functional types of visual stimulation approaches

5. What changes and improvements would you like to see made to the VIISA training format, content, and materials?

meet more often for less time, proofread manual(2), remove midterm teleconference, include more information on CVI and multiple impaired, more in depth on low vision aids, braille, etc.

6. Would you like to have an opportunity to get together with other people who have been through the VIISA training in your state for more sharing of ideas as well as to receive more training?

_8_ yes ____ no How often? **1x/yr(3) 2x/yr(3)**

For how long? **1/2 to 1 day (4) weekend(1)**

Where? **St. Louis(3), Kansas City(1), Columbia(1), MSB(1), convenient local for everyone(1)**

Check the activities you would like to see happen at such a session.

_5_ time to network

_5_ time to share ideas, materials and strategies for working with young children with vision impairment and blindness

_2_ time to review video footage of some of the children we are serving so as to obtain intervention ideas from each other

_5_ presentations on specific topics (i.e., orientation and mobility, functional vision); list topics of interest below

no response to #6 (2)

PROJECT VIISA FOLLOW-UP QUESTIONNAIRE

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Summary of Ohio # Returned: 12

1. How many children (ages 0-5 years) with blindness and visual impairment are you presently serving?_23_ Please list below the ages, degrees of vision impairment, and additional disabilities. For example: one 2 year old, totally blind with motor problems; one 9 month old with low vision and no other disabilities....

Birth to 3	3 to 5	low vision	legally blind	totally blind
8	15	4	7	2

multi-impaired (autism, hearing, CP, motor, Downs, CHARGE, language, behavior)
13

CVI(1), refractive errors(4 downs), cataracts(1), Lebers(1), ROP(1), glaucoma(1), CHARGE syndrome(1)

2. Has the training you received through VIISA helped you improve upon the services you provide to these children and their families?
_11_ yes ___ no If yes, how?

visual interest toys, more confident with skills, pick up on visual issues faster, understand preschool aspect, helped organize approach, loan materials to others

3. What materials, skills, or information have you used the most from your VIISA training during the past year?

resources for parents(5), written information to refer back to, developmental activities, both binders(1), questions for ophthalmologist, home adaptions, PAVII, function vision assessment, vision measurements, prebraille manuals, books, videos

4. What areas have you found your VIISA training to be most lacking in as you work to provide intervention services to young children with blindness and visual impairment and their families and/or local preschool programs?

assessments, refresher course, working with multi-handicapped children, lack of understanding about EI, too extensive, ways to stimulate vision, need the EI component of VIISA

5. What changes and improvements would you like to see made to the VIISA training format, content, and materials?

proofread, streamlined, refined, made less voluminous, separate workbooks,

6. Would you like to have an opportunity to get together with other people who have been through the VIISA training in your state for more sharing of ideas as well as to receive more training?
__6__ yes __2__ no How often? **1x/yr(4)**
For how long? **1/2 to 1 day(1) afternoon**

Where? **local, central location**

Check the activities you would like to see happen at such a session.
__3__ time to network
__4__ time to share ideas, materials and strategies for working with young children with vision impairment and blindness
__4__ time to review video footage of some of the children we are serving so as to obtain intervention ideas from each other
__3__ presentations on specific topics (i.e., orientation and mobility, functional vision); list topics of interest below

no responses to #6

PROJECT VIISA FOLLOW-UP QUESTIONNAIRE

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Summary of **South Carolina** # Returned: **13**

1. How many children (ages 0-5 years) with blindness and visual impairment are you presently serving? 23 Please list below the ages, degrees of vision impairment, and additional disabilities. For example: one 2 year old, totally blind with motor problems; one 9 month old with low vision and no other disabilities....

Birth to 3	3 to 5	low vision	legally blind	totally blind
6	17	6	9	3

multi-impaired (hearing, cognitive, motor, CP, seizures, shunts, head injury, Neuke's disease) 18

CVI(6), ROP(2), tumor(1)

2. Has the training you received through VIISA helped you improve upon the services you provide to these children and their families?
10 yes ___ no If yes, how?

current information for EI's, information for parents(2), ideas for classroom teachers giving child more experiences, better concept of sequence of normal development

3. What materials, skills, or information have you used the most from your VIISA training during the past year?

information on working with families(1), ideas for instructional materials and utilization, O&M, manual(2), using real objects with children, videos

4. What areas have you found your VIISA training to be most lacking in as you work to provide intervention services to young children with blindness and visual impairment and their families and/or local preschool programs?

periodic reviews throughout the year, more slots available--EI's, hard to meet needs of all children, vision loss due to head injury, ability to get materials quickly, functional vision assessments(2)

5. What changes and improvements would you like to see made to the VIISA training format, content, and materials?

update list of resources(2), make course available to non-vision teachers, one on one contact with actual students, hands on, more materials, more time to discuss the reading material, how to order materials

6. Would you like to have an opportunity to get together with other people who have been through the VIISA training in your state for more sharing of ideas as well as to receive more training?

_9_ yes _1_ no How often? **1x/yr(6) 2x/yr(1)**

For how long? **1 day(3) 1/2 day(1) 2 days(2) weekend(1)**

Where? **Columbia(6) South Carolina(1) Charleston(1)**

Check the activities you would like to see happen at such a session.

_6_ time to network

_9_ time to share ideas, materials and strategies for working with young children with vision impairment and blindness

_2_ time to review video footage of some of the children we are serving so as to obtain intervention ideas from each other

_7_ presentations on specific topics (i.e., orientation and mobility, functional vision); list topics of interest below

more information on children who are profound and severe with VI, O&M(2), functional vision assessment(3), activities for blind and multi-handicapped, levels of light box kits, preparation of teaching materials

PROJECT VIISA FOLLOW-UP QUESTIONNAIRE

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Summary of Wyoming # Returned: 6

1. How many children (ages 0-5 years) with blindness and visual impairment are you presently serving?_5_ Please list below the ages, degrees of vision impairment, and additional disabilities. For example: one 2 year old, totally blind with motor problems; one 9 month old with low vision and no other disabilities....

Birth to 3	3 to 5	low vision	legally blind	totally blind
1	4	3		

multi-impaired (hydrocephaly, child abuse, speech/language, developmental delay)
3

Retinal damage(1)

2. Has the training you received through VIISA helped you improve upon the services you provide to these children and their families?
_6_ yes ___ no If yes, how?

awareness of visual disabilities, greater understanding of child's perspective, good communication with parents, figure ground discrimination activities, visual motor activities, classroom arrangement.

3. What materials, skills, or information have you used the most from your VIISA training during the past year?

VIISA manual as reference, figure ground concerns, O&M training section(2), textbook manual, notebooks, reference material

4. What areas have you found your VIISA training to be most lacking in as you work to provide intervention services to young children with blindness and visual impairment and their families and/or local preschool programs?

visual aids, refresher course, more personal contact with instructor

5. What changes and improvements would you like to see made to the VIISA training format, content, and materials?

comprehensive visual screening kit, less travel

6. Would you like to have an opportunity to get together with other people who have been through the VIISA training in your state for more sharing of ideas as well as to receive more training?

_4_ yes _2_ no How often? **1x/yr(2) 2x/yr(1)**
For how long? **1 day(2) weekend(1)**

Where? **session in eastern part of state(3), session in western part of state(3), Casper(2), Cheyenne**

Check the activities you would like to see happen at such a session.

_2_ time to network
_4_ time to share ideas, materials and strategies for working with young children with vision impairment and blindness
_5_ time to review video footage of some of the children we are serving so as to obtain intervention ideas from each other
_2_ presentations on specific topics (i.e., orientation and mobility, functional vision); list topics of interest below

O&M